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Aging

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Aging
together
USA
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hds Human Development Services
Working with state and local agencies
to create caring communities

U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES
Administration on Aging

Aging

May–June 1982
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OLDER AMERICANS MONTH, 1982

BY THE PRESIDENT OF THE UNITED STATES

A PROCLAMATION

A nation derives its soul, strength, and character from the sum of the creative efforts of all its citizens. While we are a nation of more than 230 million individuals, we are one people—interdependent on each other for our accomplishments and our future.

We owe a special debt of gratitude to our older citizens, who have enriched, and continue to enrich, our great nation. Older Americans from all walks of life have played a major role in creating the bounties of life that bless us all.

As we have come to appreciate the reservoir of experience and depth of knowledge possessed by our older citizens, we must recognize the importance of continuing to draw on them. Older Americans have much to give, both through employment and volunteer work. In paying homage to the contributions and continued potential of older Americans, we also recognize there are those among them who require assistance from others to enhance the quality of their golden years.

As a nation, we are aging together. Opportunities and support we can provide to older Americans today will benefit all of us tomorrow. I urge all Americans to join in this call for intergenerational action that will make more meaningful the lives and potential of older Americans and our society as a whole.

NOW, THEREFORE, I, RONALD REAGAN, President of the United States of America, do hereby designate the Month of May, 1982, as Older Americans Month.

IN WITNESS WHEREOF, I have hereunto set my hand this second day of April, in the year of our Lord nineteen hundred and eighty-two, and of the Independence of the United States of America the two hundred and sixth.

AGING TOGETHER:
a message from the commissioner

The theme of this year's Older Americans Month Aging Together contains the seeds of many new thoughts and perspectives on the integration of the old, the young, and the middle-aged in our society.

In too many ways, older Americans have been segregated, viewed as a group separate and distinct from the mainstream. Individually, parents and grandparents are loved and revered, but collectively the elderly are often relegated to the outskirts and quiet corners of American life.

Aging Together means bringing older adults into the center of family and community life and offering them the opportunity to enrich America with their experience, their skills, their humor and determination, and their commitment to continue building for future generations.

With a quarter century added to the average life span since 1900, we need to reconsider our views on what is the right age for retirement and examine ways in which we can open doors for older people to continue full participation in the business of America.

Social Security, Medicare, and the wide range of services available to senior citizens may provide the foundation for stability in old age, but with the older segment of our population growing so rapidly, and still struggling with high costs which have resulted from the double-digit inflation of the recent past, new ways of helping the elderly to maintain their independence need to be explored.

There are 25.5 million people 65 and older in the United States. By the year 2000, there will be 42 million people over age 60, and by 2025, 70 million older citizens.

At the same time, lower birth rates will mean fewer younger people available to provide emotional, social, and financial support to the elderly. Fewer younger people will also mean more employment and business opportunities on the horizon for older Americans.

Beyond the practical considerations, however, are equally important emotional and social reasons for tapping the resources and talents of older Americans. Continued productivity and involvement are essential to our self-esteem and our feeling of being valued which have been jeopardized in the older population. The continued performance, involvement, and creativity of older adults will also send an important message to younger people, one that will give them new hope for the possibilities and potential of their own older years.

Although the option to remain healthy, active, and productive can be a reality for many older adults, others obviously will need special family, government and community support. About 60 percent of people over 65 fall into the "vigorous" category, but the remaining 40 percent are hampered by limitations chronic health conditions, psychological problems, a sense of purposelessness and isolation, or incomes that place them at or below the poverty line.

Older minority group members whether they are Black, Hispanic, Pacific Asian or American Indian struggle to survive in old age against greater odds than the rest of our society due to higher rates of poverty, more extensive health problems, and lower life expectancies.

Every effort must be made to explore new and better ways of bringing financial, social, and health services to the vulnerable elderly. For those suffering from chronic health problems and loss of functioning, the emphasis must be on providing services that will allow them to remain in their own homes and communities for as long as possible.

The Administration on Aging is funding demonstration programs that are redefining long-term care to include the provision of a range of services in homes and communities that will address the health, social, and personal care needs of the elderly. Homemaker assistance, home health care, home-delivered meals, and adult day care are just a few of the services that can keep the frail elderly in familiar surroundings, close to relatives, neighbors and friends.

The commitment to provide new opportunities for the vigorous elderly and to improve our system of services for the frail elderly requires the cooperation of all age groups and a more effective partnership between the public and private sectors.

Business needs to examine the validity of retirement policies and to think about ways to develop programs to retrain older Americans for second careers. Some banks and insurance companies already are consciously employing older workers, because management has found that the reliability and productivity of older workers more than compensates for adjusted or part-time work.

Several corporations are currently funding health fairs which use volunteers to screen thousands of older people across the country for health problems and disease. Drug firms are involved in new programs to educate the elderly about prescription drugs. Churches and community organizations are joining the government to finance construction of group housing for the elderly, and thousands of volunteers many of them older Americans, themselves, are bringing services, friendship, and comfort to the elderly.

Area Agencies on Aging, which receive Older American Act funds, have 37,000 volunteers helping to coordinate and deliver services to the elderly and 60 percent of these volunteers are 60 and over. In the national nutrition program for the elderly, including meals on wheels, 220,000 volunteers are helping to cook, serve, and deliver meals to people's homes.

This year, the Administration on Aging has signed a cooperative agreement with National Voluntary Organizations for Independent Living for the Aging (NVOILA), a program unit within the National Council on the Aging. The 22 national organizations in NVOILA, which include civic, fraternal, professional and religious groups, will each adopt nationwide initiatives that will generate volunteers, funds, and technical assistance from their local chapters to improve services for older people.

The fruits of these initiatives will be seen in communities across America in terms of information and referral for the elderly, telephone reassurance and friendly visiting, transportation and escort services, day care, consumer co-ops and other services and opportunities. Ties between the local chapters of the 22 voluntary organizations and State and Area Agencies on Aging will be developed by the National Association of State Units in Aging and the Association of Area Agencies on Aging to foster new collaborative efforts between public and private organizations.

This type of cooperation can be realized on an even larger scale throughout the public and private sectors. Universities, social welfare groups, corporations, unions, businesses, professional and trade associations, foundations and religious groups all can play some role in meeting the needs of the elderly. It is this comprehensive involvement within communities that nurtures a sense of responsibility and of caring for the older members of our population.

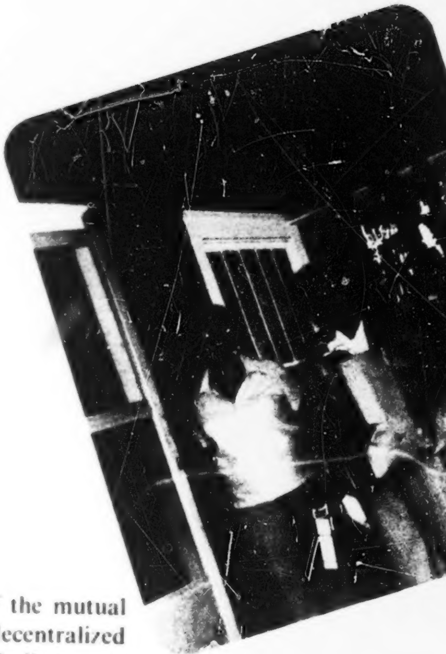
While we must work to improve the quality and range of services for older Americans who need them, we must be careful not to replace or undermine the care provided by family and friends. A recent study completed for AoA indicated that families provide 80 percent of the care that is needed for older people either directly or through financial support that purchases needed services. The care provided by family, neighbors and friends is the best type of care because it grows naturally out of long years of association and out of a mutual sense of obligation, concern, and love.

Aging Together means ridding ourselves of the fears and stereotypes we attach to old age and eliminating the false divisions we have created between the generations. It means renewing the commitment of each generation to support and care for the other with older people providing guidance, love, and a sense of continuity to the young; the young offering a helping hand in return; and the middle-aged and elderly growing and benefiting from mutual support and concern.

When representatives of the United States government participate in the United Nations World Assembly on Aging this year, one of the principles they will affirm is that "the human right to as high a quality of life as possible should not diminish with age." Together, we can put this principle into practice in all aspects of our society.

Lennie-Marie P. Tolliver

Model Project Reduces Alienation of Aged From Community



Patricia Rowe*

By the year 2000, there will be an estimated 30 million older persons in the United States, 95 percent of whom will continue to live independently in their communities. This lifestyle will necessitate innovative approaches to community-based delivery systems if their independence is to be meaningful.

To help meet the needs of those elderly living in the community, the Administration on Aging funded the *Mutual Help for Community Elderly: A Mutual Help Model.*[1] Conducted from July 1, 1976 to December 31, 1979, this model project sought to gauge the effectiveness of a community based, neighborhood service delivery system built on the concept of involving the elderly in "mutual help" opportunities. The agency developed to test the mutual help model of service delivery was the Benton Neighborhood Program for the Elderly in Benton, Illinois. The grant for the three-year period, including the research component, amounted to some $300,000.

The basic structure of the mutual help model consists of a decentralized program of small groups built on natural neighborhood boundaries. Each group utilizes the ability of its elderly members to organize, assess their own needs, and then plan to meet these needs primarily through their own efforts and resources. Thus, each group, with its emphasis on neighborliness, as well as neighborhoods, provides an organizational opportunity for the elderly to be both providers and recipients of services.

Several sociological studies related to the model have indicated that the critical distance for adequate use of services and facilities for the aged is three blocks with a neighborhood defined as no more than ten blocks. Social ecology research suggests that social and personal interventions for the elderly can be most effective when they are available to them within this distance.

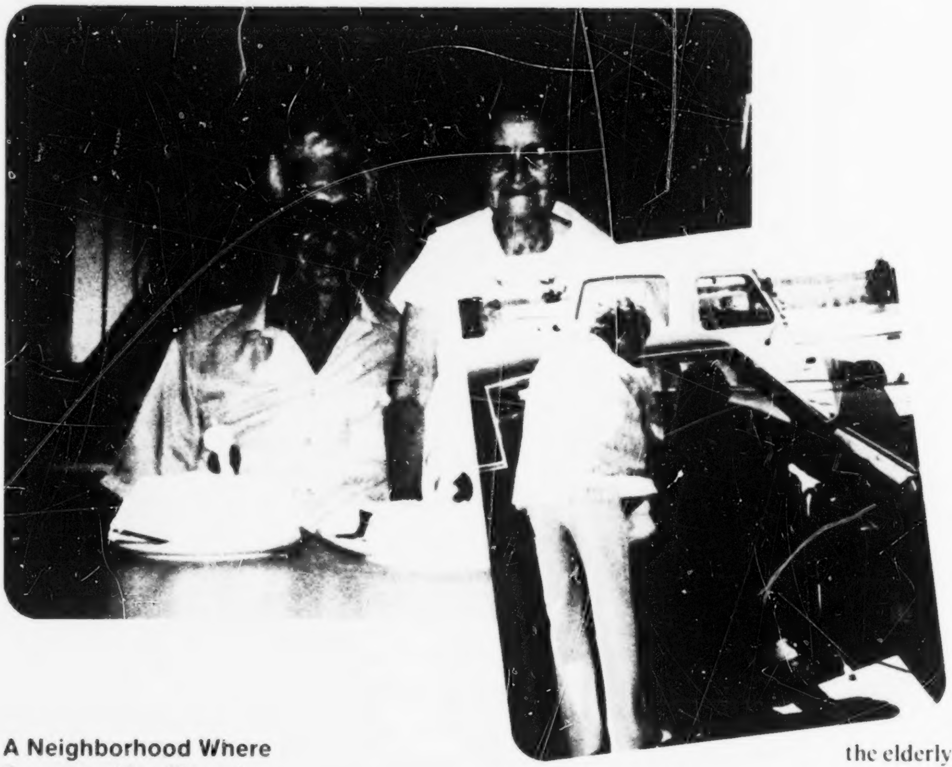
Much research has documented the lack of formal service utilization by the aged. A study completed by sociologists E. Kahana and B. Felton in 1977 in Detroit indicates the tendency of two distinct ethnic populations to bring problems to significant others who live in the neighborhood rather than to formal agencies.

There appears, then, to be agreement in gerontological literature that, as social scientist, M. Cantor, asserts, "Social support tasks most essential to mental health can be carried out on a day-to-day basis by neighbors and friends . . . ."

Traditional service delivery systems have been designed to meet specific needs of the elderly through categorical programs provided in a continuum from agency to client. Although this system frequently attempts to involve the elderly in some phases of service planning and delivery, such involvement is usually token and, at best, minimal.

**Patricia Rowe was formerly Editorial Assistant for Aging Magazine.*

[1] Free copies of the two-volume report are available from Phyllis Ehrlich, Rehabilitation Institute, Southern Illinois University, Carbondale, Illinois 62901.



A Neighborhood Where Everyone Has Moved

In 1969, Phyllis Ehrlich, Project Director of the *Mutual Help Model Project* and Assistant Professor of the Rehabilitation Institute at the Southern Illinois University at Carbondale, opened a community action agency for the elderly in a neighborhood of University City, Missouri, that was already characterized as a neighborhood in which "everybody has moved." Since it was suspected that this was not true for the elderly, a store front office was rented, the area was bombarded with brochures in English and Yiddish, and a population identification and needs assessment study was organized. Trained volunteer interviewers climbed the steps of every three-story apartment house in the area and located 1,000 elderly in a neighborhood where "everyone had moved." At the end of a year and a half, in spite of the application of recognized community organization techniques, there were only about 100 elderly residents highly involved in the successful social action program. At the city sponsored senior center, one saw that the same people who attended the Jewish Center in the area were now taking advantage of the new program as well. The other 900 in this geographically close neighborhood, which had been bombarded with information and visible services, were still behind closed doors.

This experience convinced Ms. Ehrlich of the need to design a new service in which the elderly themselves were the service providers for each other. The neighborhood focus was based on her belief that if "Mohammed can't come to the mountain, the mountain should go to Mohammed."

Small Town America

Mrs. Ehrlich chose Benton, Illinois, as the site for her neighborhood mutual help project because approximately 2,000, or 28.9 percent, of its 7,000 residents were elderly and because the community lacked formal service programs for the elderly. A further reason for this choice was that the elderly residents appeared to place strong reliance on personal autonomy a factor highly interrelated with program philosophy.

Predominantly a coal mining town, Benton's other occupational opportunities include business, the education system, and the county government, which have spawned a small professional class of lawyers, judges, and others. Members of the younger generation are leaving the town and those that remain tend to maintain the occupations and living patterns of previous generations.

The 1973 area agency on aging plan documented that other than a few services and the usual, but limited, assistance of public aid and Social Security offices, there were no formal services in Benton to say nothing of a network of services to meet the elderly's needs. It listed a number of professional and intermediate nursing homes, but their services had an institutional focus with no community orientation.

Shirley McCann, Benton's City Commissioner and Board Chairman, explains how her "romance" with the mutual help concept began in 1976 when Phyllis Ehrlich contacted the mayor to discuss the idea she had to help the elderly.

"At this time," she recalls, "I was a freshman City Commissioner and very interested in social programs for Benton. Mayor Mundell, representatives of the Oakwood Senior Citizens Club the only organized group of elderly in Benton, consisting mainly of the residents of a small Housing Unit and I met with Phyllis. She was considering submitting a proposal to demonstrate the mutual help idea in Benton. After hearing the concept of this terrific program and what she wanted to do for us, I must admit my first thought was, 'We should be so lucky; we'll never see her again.' Well, thank God we did!"

Community Workers

The primary criterion for hiring staff for the mutual help model project was that they be Benton residents because they would bring knowledge of their community to the program, and increase the potential for the program's continuation after the Federal funding period. Twelve half-time community workers were hired. The criteria for selecting workers, in addition to residence in Benton, was a history of community involvement, such as church or civic activities.

The community worker conducts outreach to all homes in the neighborhood to locate the elderly, organizes the operation of neighborhood groups, and assists both mobile and homebound elderly to work together. The community worker also works with other agencies and community organizations, encouraging linkages between elderly residents and the community, and performs such administrative functions as record keeping or statistical work determined through staff planning.

Betty Cunningham relates how she became a community worker:

"I heard about the job with the Benton Neighborhood Program for the Elderly from my daughter, Carolyn. She had heard the announcement on the radio and knew I was looking for a part-time job. The job was supposed to be two and a half days a week but our enthusiasm soon turned it into three days and more.

"I was interviewed by Phyllis Ehrlich and told there were no education or age requirements. She wanted people who were concerned about people and who had been active in school and church work. I think I was hired because of my excitement about people getting together and helping each other, or helping someone in need."

All workers were given a two-week intensive orientation training program before the initial outreach period. The orientation program, developed with the cooperation of Southern Illinois University faculty and the Illinois Department on Aging staff, included lectures in social gerontology, physiology of the aging process, group leadership and community skills, and interviewing techniques.

Outreach as Phyllis Ehrlich describes it is "a never ending process." It is important, she stresses, to make initial contacts with as many elderly as possible so that "they know a program opportunity is being brought to them."

Betty Cunningham recalls outreach efforts on the part of workers to identify and find the hard-to-locate and the first meeting of one of the neighborhood groups:

Armed with coffee and goodies, each of us fanned out to greet the long-dreamed-of neighborhood group

"Phyllis had already been in Benton a month getting an office, a secretary, and lists of elderly from various sources, like the United Mine Workers and different clubs. The Precinct Captains of both Democratic and Republican parties supplied lists and told us who was 60 and over. To get other lists, we went to churches and clubs, etc. We got lists every place we could. We began to sort out names using the telephone book, the city directory, and local contacts.

"On Saturday, before the first meeting of a neighborhood group, we mailed letters to each person who had been initially contacted, telling them of the upcoming meeting. Armed with coffee and goodies, each of us fanned out to greet the long-dreamed-of neighborhood group. Our secretary told us people would come to anything if we had food. Much to our surprise and delight, the neighbors came. I found, at the very first meeting, that these people didn't know who lived on their block. As time passed, they got acquainted with each other at the meeting and because most of them walk, they would stop on their way to and from the meeting to visit with neighbors in yards and small gardens. The group meetings are like a big happy family reunion now."

According to Carolyn Neafus, another Benton community worker, the community worker must become a familar face on the streets of the neighborhood. A worker who stays in the office can't do the job she says. Visiting the active participants, the non-participants, the homebound, the isolated, the storekeepers, and "gatekeepers" of the neighborhood are key responsibilities. Involvement of neighbors is the effective way to pyramid people-to-people contacts, she asserts, because one worker can't do it all.

She remarks: "It is impossible to fill all the needs of the elderly without the help of the neighbors and the neighborhood group. I begin every group meeting with that all-important question, 'Do we have anyone in the neighborhood who needs help or do you know of anyone who is sick?' We also discuss any casework that we have been involved in as a group. This is not gossip; the group members are really interested in the well-being of their neighbors."

Traditional case work or counseling implies a one-to-one helping relationship between a worker and client, but according to Ms. Neafus, historically the elderly have not requested such services in large numbers. Work with individuals in the mutual help model, she relates, is more broadly interpreted to include enabling the well elderly to meet daily needs, as well as providing counseling or direct service for the frail elderly, and it develops through the group process.

The first time I called on her at her home, she was very hostile towards Benton. She spoke about how her neighbors never spoke to her except for a passing nod, but after joining the Autumn Leaves, Mrs. X's outlook changed entirely.

She reports on the case of an 86-year-old woman who was a complete recluse. Mrs. W's home was located in a busy neighborhood but appeared to have been abandoned some years ago. Before the neighborhood group began, many of the neighbors did not even know the house was occupied. Mrs. W. had some contact with other agencies in the community but everyone saw her as a difficult person and believed she belonged in a nursing home. But with the help of the group and an FHA grant, Mrs. W was able to get a new bathroom, heating system, and screening for her front porch. Neighbors have taken her food, house slippers, and other household items and have provided many needed services that would never have been possible before.

"Neighborhood" Becomes a Household Word

At the end of 12 months, the community of Benton had 10 well-established neighborhood groups. The director, community leaders, and participants observed that "neighborhood" had become a household word for the Benton elderly. One major value of participation in a neighborhood group was the elimination of loneliness and isolation through social experience with people living nearby. Weekly or bi-monthly meetings became the place to enjoy oneself, share news about neighbors, develop plans to assist if needed on a one-to-one basis, and to speak out regarding community problems. The concept of membership was expanded to incorporate neighbors who were homebound as well as mobile.

During the 17-month period, 350 elderly participated through attendance at meetings; 131, though homebound, received help through worker or group contact; 139 received case management assistance from the worker or group; and 680 came to the office for such traditional services as assistance with completing forms or emergency needs. The challenge to the project, as it developed the neighborhood unit programs, was to re-educate and thus reverse the service policy that places the elderly solely in the recipient role by working with both the elderly and community service system.

Winter Emergencies

A report on neighborhood group activities during the January 1977 and 1978 winter crises provides an example of the impact of the mutual help model on the Benton elderly and the community.

During both winters extremely hazardous weather and inadequately cleaned streets made even the mobile elderly homebound, but the 1978 winter crisis affected the elderly in their pocketbooks as well. A lengthy coal miner strike at the same time led to the cutoff of pensions for the large number of retired miners in the area and made it also impossible to get coal for home heating. In 1977, at the start of the program, community workers responded as best they could to such emergencies as frozen water pipes, lack of food, or refilling of prescriptions. In January 1978, workers' outreach phone calls to group participants indicated active neighborhood networks which included assistance, particularly with shopping, from neighbors' children as well. A 92-year-old woman, who had been totally opposed to the program at its inception, called to offer her home if someone was out

of fuel. One group member called to offer money to pay for coal for an isolated neighbor who had never come to the meeting but about whom the group had become concerned.

In preparation for the winter season, the staff had developed a Youth Emergency Corps, again using the neighborhood concept to recruit and assign volunteers. The youth program had problems in its operation but was important for snow shoveling. The higher involvement of the elderly participants and the activation of the youth emergency service thus freed the staff to provide new services, including contacts with the union and coal companies to obtain and deliver coal to the elderly and handicapped. This service became vital not only to the elderly but to other Benton residents in need as the staff and ministerial alliance worked together.

A 92 year old woman, who had been totally opposed to the program at its inception, called to offer her home if someone was out of fuel.

Satisfaction With The Program

A survey taken of both participants and non-participants in the Benton community shows a very favorable response to the project. A total of 78 percent of elderly participants were rated as "very satisfied," 94 percent of relatives of the elderly felt the program was "excellent," and 97 percent of community leaders rated the project as "very good." An analysis of the Mutual Help Model indicates increased development of friendships and helping relationships, greater involvement in community concerns, and a reinforcement of social roles with a community orientation (as distinguished from home or family) through increased participation in social organizations and church activities.

"The first time I called on her at her home, she was very hostile towards Benton. She spoke about how her neighbors never spoke to her except for a passing nod, but after joining the Autumn Leaves, Mrs. X's outlook changed entirely. She became acquainted with her neighbors and they became acquainted with her. When Mrs. X was ill a couple of winters ago, friends from the group checked on her on a regular basis and carried meals to her. Mrs. X also carried food to other group members when they were ill. Mrs. X moved out of the Autumn Leaves neighborhood a year ago into an isolated area on the other side of town. There is no neighborhood group organized in this area, and Mrs. X has reverted to her previous hostile attitude and her behavior and isolationism have become a real concern. She *needs* a neighborhood group with which to identify."

One 75-year-old Benton resident, who was a worker involved in the project, noted that, "The most wonderful thing that has happended in my group, called the South Benton Neighbors, is the fact that a lady of 82 who had lost the will to live, to have friends in her home, has been made to know that her neighbors care about her, love her, and want her love and friendship. She had Parkinson's Disease so bad she could not drink liquid except with the aid of a tube without spilling it. She shakes so badly, crumbs fall from a cookie while she is trying to put a piece into her mouth. She now attends the meetings regularly and knows everyone will make her welcome and has helped by buying some cookies. She plays bingo with the group with the aid of others. She has been living in a shack, where she had a little coal and wood stove for heat. We were able to get her into the government housing project on October 31, 1977."

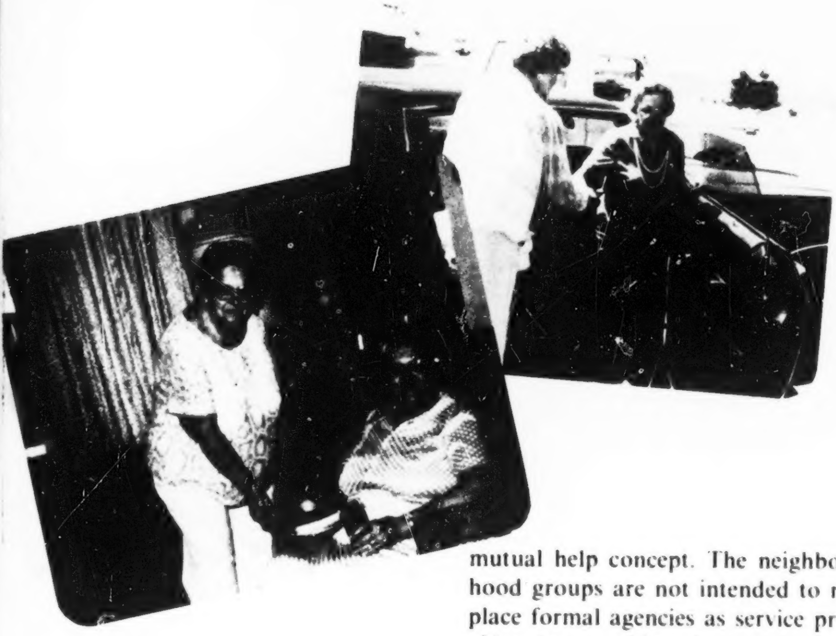
Many activities developed in Benton during the demonstration period suggest program ideas that can be adopted by other services. These included: neighbors helping neighbors with shopping and laundry, regular phone calls to shut-in neighbors, helping to hang a door in a neighbor's house, picking up groceries for a sick neighbor, inviting a lonely neighbor for Thanksgiving dinner, spending time with a neighbor after the death of the neighbor's spouse, transportation for a neighbor to visit a sick relative in a distant city, helping a neighbor with the physical work of moving, or visiting neighbors at home, in the hospital, or in the nursing home.

Social Activism

Carolyn Neafus also talks about the mutual help model's successful efforts to raise the social consciousness of the elderly in the communities where the neighborhood projects have been set up. She comments:

"Many times we organized the elderly of the community for social betterment. Participants and staff attended

After hearing the concept of this terrific program and what she wanted to do for us, I must admit my first thought was, we should be so lucky; we'll never see her again. Well, thank God—we did!



County Board, City Council, or Township Board meetings. It is difficult to organize the elderly for this purpose. In a small town they are not accustomed to speaking out for social or community betterment We did get them one by one. After a few meetings they were pros."

The Benton Neighborhood Program for the Elderly is now an established agency in the community, funded by the Illinois Department on Aging, with matching funds from the City, Township, and County governments, as well as from individual contributions and participant projects.

Its presence ensures that a portion of the town's elderly, at least, will have the social interaction and services support needed to maintain them as viable and integral parts of their community.

At the time of selection, it was suggested that the findings of a demonstration program developed in Benton could be applicable to the large part of the United States representing "small town" America. It was also felt that the similarity of problems for the urban and rural elderly are greater than their differences, indicating the potential application of this research to larger communities as well.

The program's emphasis lies not in a strong centralized structure but in the decentralized location of the service and the implementation of the mutual help concept. The neighborhood groups are not intended to replace formal agencies as service providers but to add to the community's resources by organizing the informal and formal systems into a supportive network.

The staffing pattern for the model is a traditional one, including the supervisor who serves in an administrative/supervisory position. The responsibilities of the local residents who serve as community workers are a blend of outreach worker, group worker, case manager, and community organizer. To provide program continuity, paid workers rather than volunteers are recommended. Each full-time worker could be assigned three groups, or neighborhoods, plus short term or special assignments.

In the mutual help model, the participants and staff *are* the program. Community workers, as local residents, represent the agency during working hours and afterwards in the office, supermarket, or church. Considering that staff spend the majority of their time outside the office and that they may be part-time as well, it is essential that there be one day when no regular neighborhood meetings are held. This allows for staff meetings and supervisory conferences as well as the opportunity to build team work.

The model is based on the assumption that services for the elderly can be designed to reinforce social roles, increase opportunities for reciprocal relations, and prevent or delay the loss of roles and independence.

A major factor mitigating against the continuation of a satisfying life style in old age is the change caused by social role loss. Many studies have documented declining social roles and their effect on the aged population, but the mutual help philosophy believes that social role loss need not be irreversible.

The neighbor role is reinforced in a flexible manner which takes into consideration the changing physical health needs and the abilities of the elderly. The process enables the elderly to participate in the neighbor role just as younger aged people can, rather than only adjust to progressive role loss in this area.

Participation in the neighborhood group program provides a social role opportunity as a group member. The roles of friend, group leader, or participant offer new leisure role opportunities while reducing the potential for social isolation and loneliness factors related to social role loss. At this level, the roles of neighbor and group member are integrated, creating within the neighborhood an alternative to isolation and role loss, with its consequent perception of uselessness.

For some there is yet another community level of social role opportunity including leadership roles as social activist and community organizer. The opportunities for such activities move far beyond reversing negative social isolation and instead center on positive involvement in community betterment.

Gerald Caplan, in a 1974 study on *Support Systems and Community Mental Health*, explores a positive community environment and concludes that individual responses during crises are influenced not only by stress and the individual's ego strength, but by the quality of emotional support provided by social networks. He saw even superficial links with neighbors as significant and encouraged their support by the professional community, but cautioned that such networks should not be forced into a professional mold.

HOW DO I LOVE THEE?

Norman G. Sloan

Mother lived alone and took care of herself quite well. She was retired after years of serving as Children's Librarian at the Public Library. She loved children and was loved in return.

Phase I

Then things began to change. At first, it was just being forgetful — like forgetting to bring the groceries into the house from the car until the next day, or forgetting that she had just brushed her teeth thirty minutes before. And there were the strange things that she said — plausible, but always from unknown sources — "Did you know that Henry is getting married?" or, "The city refuse department says we must separate all glass and metal from the trash for recycle."

Then one autumn day "voices" that only she could hear began calling for help and telling of doom. Slowly her paranoia grew in intensity and duration. Our constant reassurances weren't heard at all. Every weekend for years Marilyn and I had driven the 120 miles from the city where we lived and worked to Mother's home, but suddenly she could not live alone any longer.

We had long talks. We talked of finances. We talked of nursing homes. We talked of what Mother had done for us. We talked of what we should do. We talked of trying a nursing home "for awhile."

A nursing home was tried for six weeks, but Mother could be kept only in a locked section and was terribly unhappy there. Every visit consisted mainly of her begging to get out. We took her out.

Her husband, 81, and separated from her for years, kept her during the week days on his farm over the next six months. Our trip each weekend to give her a bath, fix her hair and wash her clothes revealed more confusion and paranoia as the months passed.

PHASE II

It was on my birthday in May of 1978, that I was totally surprised by a party in our home in the big city. Fifty relatives, friends, and fellow workers converged on our house to give me the surprise of a lifetime. It was great. There was so much food and so many friends. Our house in the big city was filled with laughter and relatives from far away that rainy, stormy Saturday night at 10:00 p.m. when the phone rang. It was my dad calling from Mother's house. Mother had gone into the bedroom where I slept on weekends, pulled back the covers only to discover, "He's not here." She then went running out into the stormy, rainy, darkness looking for her son, who in turn spent most of that night driving around looking for her. The police finally found her about 3:00 a.m. sitting on some steps about a mile from her home. They took her to the state mental hospital.

The next day, Sunday, was difficult at best. It seemed so hard to know what to do. Mother's release was obtained from the state mental institution after her overnight visit. It was decided to take her to a private psychiatric hospital in a nearby city.

During the next three weeks the doctors at the psychiatric hospital were able to get Mother "stabilized" with an anti-hallucination drug. We visited and talked with the doctor at the hospital concerning Mother's future care. We told him that we wanted to care for Mother in our home. The doctor told us that he admired our ambition, but that we really didn't know what we were getting into. (He was right; we didn't). "Your mother doesn't respond to anything. I'm not sure that she will even know you. I'll have the nurse bring her into my office, and we'll see." As soon as Mother entererd the doctor's office, her face lit up, and she responded, "Hi Norman, hi Marilyn." The doctor said, "We cannot get her to eat any meat. It's mealtime; let me show you." Ground beef was on the dinner plate that day. "Mother, let's eat some of this." Immediately she ate the entire portion of ground beef. The doctor was amazed.

"She's going to make a liar out of me for everything I've said. You apparently have a rapport with your mother that no one else has," he stated. "I believe you and your wife will be able to care for her in your home, though it will be difficult."

PHASE III

Mother came to live with us in the big city, 120 miles from her home, where we lived and worked. It was frightening at first. Neither Medicare nor private insurance could help in such a non-professional program. Mother had saved for years, however, and did have some funds. We felt that we would need nurse's aides Monday through Friday during working hours, on Sunday mornings, and perhaps for some Friday or Saturday evenings out. We hired two nurses aides, and we were in business.

With the establishment of our home nursing operation, we came to know a very special group of people, professional nurse's aides, who were neither R.N.'s nor L.P.N.'s. They were women in their thirties and forties, and they were great. They brought a remarkable range of skills and treated Mother with love, patience, and concern. Anna stayed with us the entire three years of our home nursing operation and was the "backbone." She worked the Monday through Wednesday shift, while the second nurse's aide worked the Thursday through Sunday shift.

The first year of our nursing home operation required some adjustment. Mother was restless up often at nights, walking around and banging doors. We took her on daily walks of two, three or four miles around the neighborhood. She liked to go to the grocery store and help by pushing the grocery cart. Never once did Mother mention that she was not happy or that she wanted to go home. Upon the conclusion of visits to her house, she would often announce "I'm going home with you."

At the end of the first year of our nursing home operation, we were rewarded with a much longed for first baby a beautiful girl, Mary Ann. Marilyn was able to return to work, leaving the care of our baby with the nurse's aides those special people.

The daily three mile walks continued during the second year. Only this year the new baby also went along either in a back pack, front pack or stroller. Three generations walking together each day was an unusual sight for the neighbors to see. Some neighbors even asked to walk with us at times.

About the middle of the second year, Mother had to have a bladder catheter. This required new skills to be mastered and more adjustments. The leg bag had to be emptied about every three hours day and night. This affected our sleeping habits.

We kept Mother looking her best because we loved her. The nurse's aides gave her a tub bath and shampoo twice each week. She got a professional haircut at the beauty shop each six weeks. Marilyn made new clothes, and each set of clothes was worn one day, then washed.

PHASE IV

The third year of our nursing home operation began much the same as the second year had ended. There were the daily three mile walks and the trips to the grocery store as before. But Mother was losing weight and getting weaker. The doctor had diagnosed her case as degenerative Chronic Brain Syndrome Disease. Midway into the third year, we awoke Mother one morning to discover that her legs were like rubber and would not even support her weight; just the day before we had taken our three mile walk. We rented a wheel chair, and purchased a hydraulic bath tub lift.

A couple of months later, we awoke Mother one morning to discover that her hands and arms had only limited use; spoon feeding was started. Swallowing became a problem; sometimes she just could not swallow at all. We rented an aspirating machine to suck fluid out of her lungs when necessary. A bed-side commode and a pulsating air mattress to combat bed sores were rented. Mother had entered into an intensive care situation.

Because of the inability to swallow on some days, it was necessary to have a tube feeding catheter implanted in her stomach. This required a five day hospital stay. It seemed strange those five days, not having Mother at home.

We were glad to have Mother back at home from the hospital. She was recovering quite well from the operation and was gaining some needed weight those last three weeks.

That final night, April 28th (10 days before our second child was born), we put Mother to bed as usual and felt good because she was doing better now. We did not know that that would be the last time we would see her alive.

When we went to awaken her the morning of April 29th, she had already gone on a peaceful passing in her sleep. It was not immediately obvious that she had passed on until the ambulance arrived and no heart beat or life signs could be detected. We were stunned.

There beside Mother's bed we were weeping, and Marilyn was stroking Mother's hair between her fingers. She had cared for that hair so many times before. We felt so helpless.

This little story was written for two reasons. The first is to pay a lasting tribute to a beautiful and devoted lady, without whose help I never could have personally cared for my Mother. She is my wife, Marilyn. The other reason for writing this is to offer encouragement to those who want to keep their older relatives at home but who hesitate to break their social routines and to ignore the well-intentioned advice of their peers. We were fortunate; the regimen of Mother's home care worked no financial hardship on us. We were enriched by the experience while the American taxpayers were saved the money for less effective "benefits."

No hint of criticism is intended of those who have, for any number of reasons, been unable to give their elderly loved ones home care. No one can pass such judgment on others. But much can and should be done by all of us to allow our aged to live and die in decency, tenderness, respect and peace.

Intergenerational Issues *

Pat Yuknavage**

When *CBS News* recently aired a TV show about the special interaction that takes place between young and old they called it a "Sort of Magic."

The *CBS Sunday Morning News* telecast focused on a group of Foster Grandparents who work with physically and mentally handicapped youngsters at Sonoma State Hospital in Eldridge, California.

Working with the disabled youths many profoundly retarded has been the highpoint of many of the Grandparents' lives. "I love every minute of it," exclaims 76-year-old Foster Grandparent Connie Robotham in a broad Scottish accent. "I never was a mother or grandmother, but now I am."

*** Ms. Yuknavage is the Editor of Prime Times, ACTIONS' official publication for the 325,000 members of the Senior Volunteer Force. Her article, "Senior Volunteers Bring Experience and Expertise to ACTION" appeared in the May-June 1980 issue of Aging.*

Dora Shafer, another Foster Grandparent, is a mother and grandmother of 13, but her work with a young resident at Sonoma State Hospital gives her life a new-found purpose. Under Mrs. Shafer's careful tutelage during the past two years, her "grandchild" Steve, has made great strides and will soon leave the institution, where he has spent his life, for a private home.

Jonathan Prince, Foster Grandparent Program (FGP) project director in Eldridge, California, points out that, "what takes place at Sonoma State is unique. Here you have two groups of disadvantaged, disenfranchised people—the Grandparents and the residents. Somehow, though, when they are put together, something happens and they are able to meet each others' needs."

Youthful Offenders

Dominick Sylvester is very much involved in what might be called work with the disenfranchised—young boys serving prison sentences at the maximum security facility in Cleveland, Ohio.

Sylvester, a Foster Grandparent and former circus performer, teaches gymnastics to several of the boys. Watching a group of six build a human pyramid, Sylvester explains "To do this you have to train. My main objective is to get them to do enough so when they get on the outside, they'll keep it up. This is the best thing in the world for their health."

Sylvester is one of 68 Foster Grandparents assigned to such facilities in Ohio. Throughout the nation, 50 Foster Grandparent projects, or 25 percent of the total, deal with youthful offenders.

The rapport and ease with which the young men and the volunteers interact is obvious. "I treat them with respect," says the volunteer, "and they do the same."

At first, Tony Rushian, the facility's superintendent had doubts about how the Grandparents and kids would hit it off. "Now there are no major problems," he says. "Many of our kids have trouble with authority figures, and, of course, that's not what the Foster Grandparents are. Many of the boys have never had the opportunity to relate to someone whose only concern is them. There is no hidden agenda."

The boys know that perfectly well. "I saw Pops (Sylvester) here doing handsprings," says one teenager, "and I thought, 'I can't do that!' But I started working out with him. On the outside I used to get high a lot. But this is a natural high!"

The other boys laugh and shake their heads in agreement.

Sometimes potential is hard to spot in emotionally disturbed teenagers. "Pops" Free, a Foster Grandparent in Edgemeade, Maryland, has never given up on the kids he works with. They, in turn, have reciprocated that love and have talked about it openly—to the Senate Aging, Family, and Human Services Subcommittee. In testimony before the committee, one youth said that he "loves Pops." and that the residents of his school need "Foster Grandparents for many reasons...they are wonderful people."

Working at a boy's reformatory in Red Wing, Minnesota, Foster Grandparent Charles Hauke thinks the youths he deals with, some of whom have committed serious crimes, are just plain kids, looking for some love and attention, but who "go about it in the wrong way."

"I don't preach and I don't discipline," says the 81-year-old volunteer. "That's not my job. I'm here to listen and console as best I can."

The natural affinity he has for the residents is self-evident. When he comes to work, they flock around him, vying for his attention.

Life at the Red Wing Training School brings

**ACTION is the national volunteer agency, which administers the Older American Volunteer Programs. They include the Retired Senior Volunteer (RSVP), Senior Companion, and Foster Grandparent (FGP) programs.*

RSVP Volunteers—numbering over 300,000 men and women aged 60 and over—serve in almost 930 communities nationwide, while some 18,000 Foster Grandparents work with children with special or exceptional needs across the nation. The 5,000 Senior Companions provide care and attention to the frail elderly. Foster Grandparents and Senior Companions are usually low-income people and they receive a small stipend for their services. RSVP participants do not receive payment for their services.

Recently, the agency has become involved in helping communities solve local problems through new volunteer initiatives in drug prevention, elimination of illiteracy, aid to runaways, the Vietnam Veterans Leadership and the Young Volunteers in ACTION programs.

The Bears'
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17

daily challenges for this Foster Grandparent, but he says, "It's better, my friend, to wear out than to rust out . . . "

The challenges and the rewards are many for another volunteer, Francis Abby, a retired manufacturer's representative, who now serves as a Foster Grandparent at St. Joseph's Villa, a boy's home. For Abbey, the greatest rewards occur almost daily. "When the toughest little guy in the cottage falls asleep on your lap, when the boys spend their craft period making a present for you, or when they surprise you on your birthday with a coffee cup that reads: 'The World's Greatest Grandad!' "

Handicapped Youngsters

"They're just crazy about him," says Christopher Public School Principal John Glazier, referring to Retired Senior Volunteer William Riebel, who works with handicapped youngsters in the Chicago, Illinois school.

Riebel, a 71-year-old retired sheet metal manufacturer, seems an unlikely candidate for a classroom setting, but officials at Christopher School say he teaches like a pro. His knack with handicapped children impresses even seasoned instructors.

The volunteer uses teaching aids, which he had designed and built, to convey mathematical concepts. One 12-year-old, whom Riebel has been working with for some time, can neither speak, walk, or use his hands. The situation doesn't depress Riebel who says: "Oh, no, I always think positively. I believe every child has potential. I don't even ask what's wrong with the kids. I think the less I know the better. I just try to bring out their greatest potential."

Lifetime Learning

Working to one's greatest potential is a goal that crosses all generational lines. Now, senior citizens in Weston, Mass. are achieving this objective through academic study at the newly-created Lifetime Learning Institute for community residents aged 60 and over.

Started in 1977 by a small group of former academics, now volunteers in the Retired Senior Volunteer Program of Weston, the program boasts a student body of 350 engaged in such fields of study as history of the Middle East, conversational French, world religions, poetry, the classics, and economics.

Former Wellesley College Professor Dr. Janet Guernsey, who specialized in neutron physics research, was reluctant at first about teaching senior students. She has found, however, that working at the Lifetime Institute has been rewarding and challenging. "I can talk about a lamp chimney and they know what I'm referring to because they're my own age."

RSVP Volunteer Rev. Daniel Lineham, former mathematics and physics instructor at Holy Cross and Weston colleges, relishes the way his older students plunge into their work. Says Father Linehan: "Women often feel at first, 'I'm just a housewife. I don't think I'll understand.' But, by the time they're through, they're not afraid to try. This is a great service."

The Lifetime Institute seems to be incredibly successful because it brings together two groups of people who have much to share retired professors who would otherwise be put on the shelf and senior citizens who have the practical know-how aquired over a lifetime.

Being a late blooming student may be more beneficial than not, claims Dr. Chester Williams, another instructor at the Institute. Williams quotes a Harvard professor who wisely advised his students: "You should never study history until you've lived it awhile."

Ben Nayson, RSVP volunteer in Bangor, Maine, is a man who enjoys living life to its fullest. Up until a few years ago, Nayson, now 93, drove the RSVP project's van almost 1,000 miles a month. He also traveled cross country and shot 1,800 slides, which he now shows to residents at local nursing homes. Nothing seems to be a deterrent to this man who uses two canes to walk.

Nayson also lectures adult education and high school classes in Bangor on the physical and mental aspects of aging. Says Nayson: "I find the high school students' questions and comments about aging issues intelligent and very penetrating."

To Nayson, volunteer work is good for man's soul. "I tell people when they retire, 'If you want to get the most out of your new life, find something to do that helps others but can't pay you for your work.' I don't know of anything else that can give greater satisfaction."

The Old-Old

Intergenerational issues are not only those of the old working with the young they can also include the old working with the old-old, as this country's growing group of centenarians are called.

That was the case of Peggy Bennett, 71, who served as a Senior Companion to Alton and Grace Dove in Yakima, Wash., But, shortly after Mr. Dove's 100th birthday, he died, and that hit Mrs. Bennett very hard. "I miss him very much," she says. He was such a jolly man. When I arrived at the Doves' home, he'd say, 'Come in my little sweetheart!' He had a wonderful personality."

Mrs. Bennett continues to serve 93-year-old Grace Dove who is doing well on her own. "Working with the Doves has helped me tremendously," Mrs. Bennett declares. "I have learned to accept my own aging more gracefully and to avoid some of the mistakes they made in their later life."

Death and Dying

Working with the terminally ill has helped other Senior Companions in the Midwest better cope with the issues of death and dying. Says Doris Barr, a Senior Companion for the past four years in Indianapolis, Ind., "It has been difficult working closely with people whose lives, I felt, were soon to end. Even with our limited time together, I've grown from these relationships. I hope I've brought some joy and comfort to these people in the last days of their lives."

Senior Companion John Petersen in Waterloo, Iowa talks about the stress involved in working with the terminally ill. "If you are sincere and dedicated, sometimes you get a little too involved in the situation facing your client and the family," he observes. "This is understandable. You do this work out of love and love means involvement."

The emotional toll this type of volunteer assignment exacts on the volunteer is profound. "At times, you think, 'I just can't go on.' Mr. Petersen continues, "and, it's just about then that a case comes along that you can't refuse. And, you don't."

Young and Old Together

The other side of the intergeneration spectrum is that of the young serving the old. Through a new and special ACTION initiative called the Young Volunteers in ACTION, young people will have a chance to help meet the needs of older people in their communities.

Volunteers, aged 14 to 22, are now beginning work in 10 projects nationwide. They receive no pay for their service but they will receive the satisfaction of knowing they're doing something that counts. That could be weatherizing older residents' homes, or visiting the homebound elderly.

The Young Volunteers in ACTION is one of a number of new ACTION programs to help implement President Reagan's call for greater citizen involvement in solving local problems.

According to the Roman statesman, orator, and authaor Cicero, there is a little of the child and the elder in all of us. Almost 2,000 years ago, Cicero said:

"Give me a young man in whom there is something of the old, and an old man with something of the young: guided so, a man may grow old in body, but never in mind."

Creating Caring Communities

Linking the Generations

Carol Tice*

At age 78, Evelyn Smith lives with her husband in the same community where two of their three children reside. Their extended family is highly respected, and the affection and concern of neighbors and family members for Evelyn is evident. Nevertheless, some months ago, Evelyn felt herself sinking into a deepening isolation and depression as her role as a useful and contributing citizen faded. A recent loss of hearing had shaken her confidence in trying to contribute in areas in which she was welcome to do so, such as in her local church. She felt embarrassed, bereft, and quite sure that others had "taken over."

Fortunately for Evelyn, an intergenerational program operated by the Ann Arbor, Michigan, public school system has opened up an opportunity for her to make a contribution that is bringing a new sense of well-being and meaning to her life. Called Teaching-Learning Communities (TL-C), the program brings together people of all ages within the regular school curriculum to exchange skills, knowledge, and experiences in the arts and humanities.

Evelyn now volunteers one afternoon a week at a nearby elementary school where she is encouraged to rediscover her ability in painting and to assist 10- and 11-year-olds in a small art class. The setting is nonthreatening, and she receives encouragement from the children as well as from others who assist in the program. Evelyn serves as a teacher-learner as she shares with the young students painting techniques that she learned long ago. At the same time she discovers new ones. Communication flows easily, growing out of the children's natural ability to relate to people.

In the TL-C Program, the older person is encouraged to make use of a skill that he or she acquired in youth or adulthood whether it be painting, sewing, woodworking, or cultivating plants and to practice and refine that ability along with the children who are developing skills in the same or a related area. Working side by side in the classroom, old and young serve as natural teachers to one another.

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* *Carol Tice is the founder of the TL-C Program in the Ann Arbor schools, and president of New Age, Inc. In 1979, she was appointed to serve on the U.S. Commission on the International Year of the Child.*

Ann Arbor started the TL-C Program in one school in 1971 and the following year obtained a small grant from the Michigan Council for the Arts to expand the program to three other schools. Then, in 1974, the city received a $154,000 federal grant under Title IV-C of the Elementary and Secondary Education Act (ESEA) to develop the intergenerational teaching-learning concept into a full-scale demonstration program that would be carefully evaluated and serve as a model for other communities across the country. Over the past 11 years, the program has spread to both metropolitan and rural areas in 50 states, with costs to local school systems ranging from as low as $200 a year in a small rural community to $13,165 a year in Ann Arbor where the project is operating in eight schools. Ann Arbor's TL-C budget covers one half-time program coordinator, eight half-time community aides, supplies and transportation.

Unlike traditional volunteer programs in which a school has a specific need that the volunteer fills, the teaching-learning concept invites older people to share something that they value from their lifestore of experiences, skills, and work. Since further exploration in a wide range of related areas is encouraged, an excitement about learning, life, and the world is experienced, and the interaction between the generations is enriched.

In a TL-C classroom, relationships are established and, sometimes, rediscovered. On Evelyn Smith's first day at school, she noticed a young man watching her. Ed, age 25, and severely hearing impaired from birth, was also finding his way back into the mainstream of community life through the TL-C Program. As he watched her set out her paints in readiness for the class, he remembered that she had been a beloved Sunday school teacher some 20 years before when he was in kindergarten.

The meaning of their reunion cannot be measured alone in the hugs and easy laughter that naturally occurred in that moving encounter. Suddenly this older woman and young man had new things to talk about. Communication was easy even though both were hearing impaired. Whereas Evelyn had been the primary teacher 20 years ago, Ed now had the experience and ability to cope in a soundless world, a skill that Evelyn desperately needed. He stood as gracious and confident proof that life could and does go on in spite of severe losses. Evelyn could trust herself now in a way that she was unable to do before.

Ed and Evelyn come to school on a continuing basis, giving of their insights to children who reciprocate with acceptance, love, and appreciation. The interaction provides a two-way street benefiting all who participate.

Will Evelyn's own grandchildren view the aging process as a frightening and difficult task as they remember their grandmother's frustration in trying to cope and compensate for her loss of confidence in communication? Or will they carry with them the picture of aging experienced by the children at school in the T-LC Program where Evelyn's courage and willingness to try new learning modes provides a model for their own learning styles throughout life?

Intergenerational programs, designed and implemented on the teaching-learning conceptual model, provide many benefits beyond the heartwarming encounters that take place in the small amount of time set aside each week for activities.

Through evaluation and research carried out since 1974 with support from ESEA Title IV-C and the Charles S. Mott Foundation, many of the benefits for all ages have been identified.

The older participants can feel confident that they are contributing in a substantive way to the lives of children. The presence of older people and their unique attributes exert an influence on the child's self-concept and feelings of self-worth, ability to think creatively and independently, academic skills, historical and cultural perspectives, attitudes toward work and leisure, and understanding of aging.

Self-worth is strengthened through affection and respect from people who have lived many years. When the children were asked to respond to the question "Working on a project with a 'grandperson' (T-LC volunteer) makes me feel ______," some of their responses were: "very good and grown up," "like I'm reaching a certain goal," "very good inside and outside," "proud."

Increased motivation in learning academic skills was clearly identified. While the children's vocabulary increased and mastery of special skills and knowledge was documented, the most popular gain in the academic area was identified by children and parents as the application of basic academic information. For example, mathematics became interesting and important when it was needed to carry out a woodworking or sewing project. The use of small printing presses reinforced the goals of learning to write well and spell correctly.

History and cultural traditions took on new meaning when enhanced by living memories. Mentors and role models were adopted. Career information and guidance were available from people who spent a lifetime working in a particular vocational area.

The teaching-learning communities concept serves as a link for another age group which is often isolated from the social and cultural mainstream. Women in the middle years are encouraged to serve as aides in the program. The aides, either volunteer or paid a small stipend, provide the support and guidance that make it possible for many fragile older people to participate. Over the course of the program, nursing home patients have been brought to school to share their special gifts with children. In addition to the major benefits to the older person in that interaction, studies indicate that the children benefited and so did the person in the middle years who served as the aide or facilitator.

At a stage in life when many women are faced with an "empty nest" and stereotyped prospects of a "downhill" aging process, the women who serve as aides find new avenues to utilize their highly developed nurturing skills. Often, experience in the T-LC setting builds self-confidence which enables the women to move into other employment in the community. These benefits are immediate and tangible. Less definable and more future oriented are the positive attitudes toward aging gained while working with older people as they, in turn, work with younger people. A rehearsal for one's own aging is possible in such a setting. Actual coping and adapting skills are transmitted with reassurance and grace by elders who have mastered the changes that come in the later years.

The question often arises in the teaching-learning environment. "Who gains more, the young or the old?" With a grant from the Charles S. Mott Foundation in 1979, research was conducted to identify benefits to the older volunteers participating in the T-LC Program. Two of the most impressive gains identified through this study and others conducted through the School of Nursing, University of Michigan, were the perceptions on the part of the older T-LC volunteers that their relationships with family and friends became more satisfying and that their physical health as well as general sense of well-being improved.

Feelings of isolation and loneliness were overcome through relationships that ranged from casual once-a-week involvement to becoming members of extended "families of choice." When Grandma Alice, age 82, fell ill and could not come to school for two months, Mark, age 10, called her every day to report the latest news in school. "I had to hurry up and get well so I wouldn't miss out," Alice told her doctor.

Many older people felt that their lives had become useful and of value again. The following comments are typical of spontaneous expressions: "I think I'm learning   I think I'm learning a lot . . . ." "These few hours help to take the pain away." "I can't keep the tears from coming. I finally found a way of feeling worthwhile."

The benefits of intergenerational initiatives continue to multiply as one looks at the gain for the community as a whole. In times of economic stress, one small investment is maximized as it serves three generations simultaneously. When established with high levels of personal commitment, the substance of the program has continued over a 5-10 year period, and the financial investment has remained minimal. Once in place, informal networks of learning and caring are set in motion that begin to restore some of the values reminiscent of and cherished in rural America.

Schools have become a major focal point for this regeneration to take place. Key components for success are a welcoming and supportive attitude by the school staff involved. Leadership and an essential sustaining commitment often come from women in the middle years from the community, much of it on a voluntary basis. The resources are there and accessible. All it takes is somebody to bring them together.

While the T-LC program began in a local elementary school and was originally designed to respond to educational needs of children, the intergenerational equation has reached dimensions far beyond those normally thought of as taking place in schools. Several models exist where the school lunch program has been opened up to include older people from the neighborhood. Enrichment for mind and spirit is provided as well as an inexpensive and wholesome meal.

A recycling project utilized the annual school rummage sale to assist older people in the neighborhood to clear out things they no longer needed. Payment on consignment brought some welcome cash to the elderly and "business experience" to the young people.

An intergenerational repair shop was set up so that young people learned important skills while items were being returned to working order. Applications of the teaching-learning concept are endless.

As the New Federalism challenges states and communities to assume more responsibility for the education, health and well-being of their citizens, the invaluable energy of compassion must be channeled to create structures and programs that foster contact between the generations. Too often, the same life requirements are shared by more than one generation, but are dealt with in an age-segregated approach. The duplication is costly in more than dollars.

Models for utilizing schools as intergenerational facilities now exist. Churches, hospitals, service organizations and other settings are beginning to tap the potential resources in bringing old and young together.

Intergenerational strategies offer a unique way of using existing and often untapped resources with minimum financial investment and maximum benefits. Not only is the approach cost effective but it also reaches individuals, groups, and communities in ways that begin to restore a healthy human ecology.

To design and implement such strategies, professionals and volunteers will need to develop some new ways of thinking, planning, and working.

Assistance in this process has been provided by New Age, Inc., a non-profit center for intergenerational education, service, and research, established in Ann Arbor in 1979. The center has been utilized in this country and abroad as a resource in designing and implementing intergenerational initiatives at local, state, and national levels. In 1980, with the cooperation of the Smithsonian Institution Office of Symposia and Seminars, Michigan State University, and others, a conference of selected national leaders from the areas of education and the human services was held at Wingspread, the Educational Conference Center of the Johnson Foundation in Racine, Wisconsin. Results from the conference on "Linking the Generations for a Caring Society" are to be released soon in a "Wingspread Report" by the Johnson Foundation. Other conferences are in the planning stages.

New Age also serves as an outlet for guidebooks and other materials on ways to develop intergenerational programs using the teaching-learning concept. The award winning (Milan, Italy 1981) 16 mm film "What We Have," co-produced with the University of Michigan, is a motivating and teaching resource. Based on the experience in using the film across the country, New Age is in the process of producing "All We Can Be," a film that will draw on the intergenerational potential in guiding young adolescents in lifetime choices.

Recognizing the need for learning opportunities to develop new modes of thinking and skills on the part of professionals and volunteers, New Age is working cooperatively with the Institute of Gerontology, University of Michigan, (Ann Arbor) and Bank Street College of Education, New York City to provide summer training workshops. Church groups and other organizations, such as the American Association of University Women, have taken initial steps in planning regional and local workshops. Further information can be obtained by writing and including a return self-addressed and stamped envelope to New Age, Inc., 1212 Roosevelt, Ann Arbor, MI 48104.

SCORE

VOLUNTEERISM AT ITS BEST!

Harriet Premack Soll*

In 1980, James Pinto, was chosen California's "small business person of the year." His is perhaps the most successful single SCORE[1] business counseling effort of the past several years.

Born in India 43 years ago, Pinto, who was an electrical engineer, came to the United States in 1966 from England. He settled in the San Diego area where he educated himself in American business principles by interviewing business and industrial leaders and by reading free Small Business Administration (SBA) materials. When he began his company, Action Instruments, he was the only employee, but he kept reading SBA publications, and whenever he found a word or a procedure he did not understand, he called the SCORE people in the San Diego SBA office.

Today Pinto has about 325 employees and his annual sales have skyrocketed from $70,000 in 1966 to $16 million in 1981. Exports account for about 30 percent of his gross sales, and he owns a subsidiary weighing systems company, Hardy Scales, Incorporated.

"It's an amazing resource," he says of SCORE. "For eight years, I never met my counselor, but he certainly helped me."

Six years ago Pinto finally met his "invisible counselor," James G. Black, who now is serving his second year as chairman of the National SCORE and ACE[2] Council. "Just in time to persuade him that his business was growing too big to be a one-man operation any longer," Black said recently. "After the dust settled, we became good friends and have been ever since."

SCORE, the Service Corps of Retired Executives, was initiated by the U.S. Small Business Administration (SBA) in 1964. With a revolving membership of nearly 8,500, it is the largest single volunteer resource the SBA has in its ongoing effort to help members of the country's small business community, and one of the largest active volunteer organizations in the country. The essence of SCORE is its person-to-person advisory relationship which provides an executive talent pool. Retired executives in the organization welcome the opportunity to assist small businesses while small business owners and managers welcome their help and put their experience and expertise to good use.

Several years after SCORE was born, it was augmented by ACE, the Active Corps of Executives, which is exactly what its name implies. Active participants in the business community provide counseling when they have the talents and/or experience required by specific small businesses which members of their local SCORE chapters do not have. This past year, by a vote of the National SCORE Council (NSC), the organization's self-governing body, the two groups were offi-

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[1] Service Corps of Retired Executives

[2] Active Corps of Executives

cially combined and are now known as the SCORE and ACE organization, governed by the National SCORE and ACE Council (NSAC). James G. Black of San Diego is the current national chairman of the NSAC which has quarterly meetings at the SBA headquarters in Washington, DC.

There are SCORE and ACE members-at-large in outlying vicinities, but the majority are organized into 397 SCORE chapters which often include a few ACE members and six ACE chapters. These are located in every state and in Guam, Puerto Rico, and the Virgin Islands.

The importance of SCORE's volunteer efforts lies in the broad scope of the membership's experience, in its flexibility and willingness to update its approach and take on new responsibilities, in its wide diversity of talents, and in its readiness to combine resources and work with other volunteers be they individuals or organizations with whom they share mutual objectives. These include growing numbers of Chambers of Commerce, national business and professional organizations, and SBA-sponsored programs such as the Small Business Institute, encompassing 450 schools of business administration, and the 19 Small Business Development Centers (SBDC) located in 18 states and the District of Columbia.

In a typical year, members participate in numerous workshops on every subject from Pre-Business to the Importance of Recordkeeping. They may be discussion leaders or take part in one-to-one talks with attendees after the sessions, or both. Members are active in co-sponsored workshops such as crime prevention with local police and/or sheriff department representation; tax institutes with representatives of the Internal Revenue Service; Business for Artists with the National Council for the Arts; Exporting for Small Business with the U.S. Export-Import Bank, the Commerce Department and the Overseas Private Investment Corporation. But the most talked-about, and frequently the most praised, work SCORE people do is their one-on-one consulting with business people who have problems.

Last year, SCORE counselor Sherman Huff saved a florist shop in Topeka from bankruptcy. A team of counselors reorganized the governmental functions of a small North Carolina town so it could meet its obligations without raising taxes. Mel Kassel of SCORE Chapter #34 helped suburban mother Jean Close open a specialty shop and win the Greater Cincinnati Chamber of Commerce award for the Small Business Person of the Year within five years.

Last year, also, a series of five business seminars to meet the special needs of the Los Angeles Rams was set up by members of Orange County SCORE Chapter #114. Doug France, the All-Pro offensive lineman who initiated the effort, said the Rams wanted business training for possible future enterprises when their playing days would be over. Special seminars, tailored to their specific needs, were given on franchising and restaurant management, legal organization, finance and record keeping, site location and business insurance.

In Des Moines, Iowa, Homer Goodner, a SCORE counselor with more than 40 years of restaurant experience, brought business success to ex-teacher, bagel baker and kosher deli owner, Bill Ohringer. From Molokai, Hawaii, SCORE member Henry Yamashida was sent to American Samoa at the invitation and expense of its government. He spent several days there inspecting the island's power generation and distribution system. As a result of Yamashida's detailed report, a complete overhaul of operating procedures in American Samoa's electrical system was instituted.

In 1975, retired race-car driver Rodger Ward, with two Indianapolis 500 wins to his credit, opened a tire business in Southern California. His name drew customers, but he soon realized he lacked business management experience.

"From the outside, running a business looks easy," Ward said, "but we didn't have the right kind of records, sales were all on credit; we were fighting a cash flow battle." Armed with an SBA loan and counseling by retired tire manufacturer and district sales manager A. T. Kline, Ward overcame his problems.

Although their number is small, women are playing an important role in SCORE.

Ward says, "whether learning to be a professional race driver or a good businessman, you can't be too proud to ask for help. In both instances, you profit from learning the right techniques," and he did. Almost immediately, gross profits increased 12 to 15 percent over the preceding month as some of Kline's recommended suggestions were implemented.

Not all cases show such dramatic progress. Some, unfortunately, are too far gone by the time assistance is requested for the counselor to do anything but make the closing of the business as painless and as cost-efficient as possible; or the counselor may show an owner how to get ahead by not spending money as Harold Hanson did for Tracey Newmeyer, operator of a mechanical and electrical repair shop in a Salt Lake City suburb. Hanson's "reward" came in a happy letter from Newmeyer saying "I'm sure thankful you talked me out of that electronic calculator . . . the way we're doing things now it would be a complete waste of money."

At other times, the best advice a counselor can give would-be private entrepreneurs is not to go into business at all. One story that Joseph G. E. Knight, former National SCORE and ACE Council chairman, is fond of telling concerns his interview with a young insurance man who wanted to start a family shoe store.

"He had done his homework," said Knight. "Talked to store owners, found a location, made a market survey, even worked up a sort of profit and loss projection. Said he expected to gross about $50,000 the first year, $75,000 the next, with a net annual profit of 10 percent."

I asked him just two questions," Knight continued. "First, 'What was your pay last year?' He replied, 'About $11,000.' Next, I asked him what 10 percent of $50,000 was. He looked me straight in the eye and said, 'To ---- with it.' I never saw him again."

Then there is the Cincinnati husband and wife team who were in danger of losing their carpet cleaning company. SCORE counselor Ed Sturr saved them $2,000 after four visits by suggesting legitimate tax deductions which they were not taking. Later, he rearranged their service schedule to save them both time and money in truck routes, and put their operation on a 24-hour a day basis so they could handle more commercial jobs. The owners were able to expand their franchise from the Greater Cincinnati area into Dayton, Ohio.

Much of SCORE's counseling is short-term. Many questions are answered over the telephone by members in SBA District offices or in the ever-growing number of Chamber of Commerce Resource Centers which they staff. Callers are urged to come in whenever possible. Sometimes, one intensive counseling session is enough to direct a would-be business owner in the right direction. But periodically, a counselor becomes "attached" to a company. Sometimes, having rescued a business from failure, a counselor may feel greater responsibility to work along with it, to see it securely on its way to success. If the owner needing assistance cooperates and improvement is noted, SCORE counselors have been known to continue with cases for several years, guiding them frequently to remarkable expansion.

SCORE members do not seek praise or honors. Most of them, as their name implies, are retired executives who have had their share of success along the way.

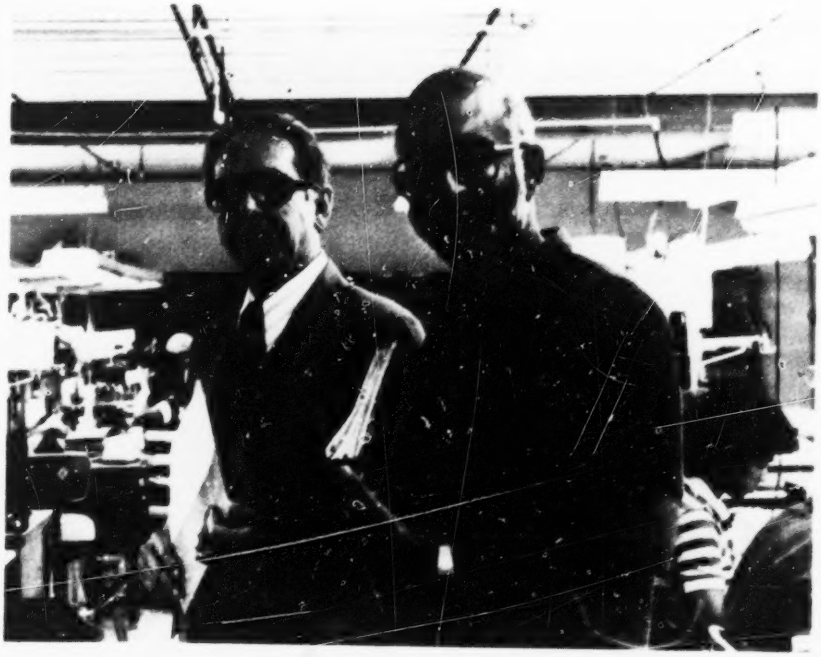
Take the case of the Institute of Modern Procedures, (IMP) for instance. A minority-owned business, IMP has three owners: President Ida Moore, for 17 years an Air Force data processing supervisor; Vice-President Elizabeth C. Proctor, also an expert in data processing; and Secretary-Treasurer Robert Miller, a retired Army colonel. The company had its origins as a school for keypunch operators, but soon moved into the larger field of data processing and programming. There was more work to be done and more opportunity. But receipts were slow and the payroll had to be met.

By 1973, the company finances were running $400,000 behind. In desperation, the officers turned to SBA for assistance. SBA determined that they were eligible for Section 8(a) status under the Small Business Act. This gave IMP the advantage of eligibility for Agency help in securing Government contracts, a certain percentage of which are set aside by law for minority and other disadvantaged companies. In essense, the SBA became the prime contractor, seeking out work for IMP until the company was on a firm footing and able to fend for itself in this highly competitive field.

Better yet, according to the company officers, SBA introduced them to SCORE counselor Julius Davidson now 84, who, in their words, "has been a member of the team ever since." Highly experienced in financial management and contracting, Davidson had been the chief fiscal officer of the Library of Congress for 17 years before his retirement.

Davidson's first step was to study the company's financial statements. From them he determined that they needed a system of operating procedures, that they must always work with signed contracts, and be prompt both in their payments and in their submission of accounts due. Within three years, with the additional contracts coming in due to their 8(a) affiliation and the watchful eye of Davidson, the company was in the black.

Today, IMP is a thriving business. Its books show a current gross income of $6 million, with a net worth of $750,000. Some of its regular customers with whom IMP has contracts are the Navy Department, the Department of Education, and the Department of Health and Human Services.



Says Davidson, who sees them officially about once a month but is always available to chat on the telephone, "The company has over 250 employees, half of them minorities, and it has expanded until now it consists of seven offices from Alexandria to Baltimore."

SCORE volunteers are also active in disaster relief efforts.

A year ago, a tornado hit the small Ohio community of Cardington, midway between Columbus and Mansfield, literally wiping out the 30 establishments in its business section. SCORE volunteers came from both cities, working with owners on the details of rebuilding their businesses, on advisable levels of inventory, and on constructive changes since rebuilding was a "must" for everyone without exception. By the time the deadline for disaster loan applications to be made with SBA disaster loan personnel arrived, the owners knew how to apply for them and most of the 30 businesses were at least partially operational.

Although their number is small, women are playing an important role in SCORE.

In 1975, Mary Riddell Castleberry, charter member of Jackson, Mississippi SCORE Chapter #250, was given the National SCORE Volunteer of the Year Award. She is the only woman ever to be so honored. Women probably make up less than 10 percent of the SCORE membership, although more are now coming into ACE. Mary often says the honor was the highlight of her life.

President Gerald A. Ford sent a letter of congratulations praising her both as a businesswoman and a humanitarian. The National SCORE Council and SBA officials and staff feted her with a reception in Washington. She has also been Mississippi's Woman of the Year, and the recipient of numerous other honors.

We gain a great deal just from knowing that we still have something to give to others.

Until an automobile accident put an end to her work as Public Relations Manager for Avon Products' Southern Region, Mary Castleberry combined a busy career with enough volunteer work to fill a fulltime schedule.

For two and a half years, and, to a lesser degree today, she devoted her counseling efforts primarily to the minority inhabitants of the Delta area, and logged more than 15,000 miles back and forth across the county. Among those she began counseling at that time was the new owner of Graves Grocery and Market, Joseph Graves, a Baptist minister. Born with congenital infirmities, Graves started doing odd jobs in the store at age ten. When the owner died, he bought the store from the widow with an SBA loan, but his lack of any formal education made it difficult for him to handle the financial details with which he was suddenly confronted.

When the loan began to turn sour, Mary was called. She quickly won Grave's confidence through her rapport with Charles Bonnermon, President of the Delta Ministry who is Grave's good friend. Mary counseled with Graves regularly until he could operate the store in a businesslike way.

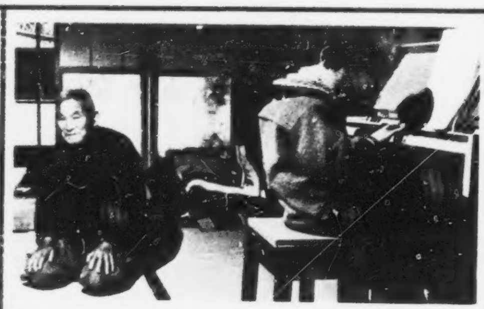
Today, Mary Castleberry is as active as ever, juggling seven different counseling projects varying from a printing shop at New Albany to a statewide research project designed to make native blueberries an important cash crop through the development of a method for preserving them by dehydration. She continues her good works and participates actively in many state committees and conferences.

SCORE members do not seek praise or honors. Most of them, as their name implies, are retired executives who have had their share of success along the way. Their recompense, if one should ask, comes from sharing their business knowledge and experience with the small business people of today.

"We hope they will gain something of value from us," one of the founding SCORE members said recently. "Those of us who counsel know that we gain a great deal just from knowing that we still have something to give to others, that we are although retired still an essential, necessary part of today's society."

New Developments on the World Assembly on Aging

Mary Jo Gibson*



Representatives from nations around the world will soon meet for the U.N. World Assembly on Aging. The Assembly is to be held in the Hofburg Palace in Vienna, Austria from July 26 to August 6. The agenda will include recommendations for action at the national and international levels in such areas as income security, health, housing, social services, and education.

The Need for a World Assembly

Dramatic increases in the number of older persons prompted the U.N. General Assembly to adopt the 1978 resolution which authorized the Assembly on Aging, which is the latest in a series of "single-issue" forums on topics of global concern. By the year 2000, there will be nearly 600 million persons 60 and over[1] a figure nearly double that for 1970. Due to declining birth rates coupled with rising life expectancy, all regions of the world will soon experience an aging of their populations increases in the proportion of older persons to the total population. These demographic trends challenge nations to find ways to provide for their growing older populations, and to cope with the effects of population aging on economic and social development.

The most rapid increases in the percentage of older persons are taking place in developing nations, which as a whole will experience a 130 percent increase in persons aged 60 and over[1] between 1975 and 2000. This rate of increase is considerably higher than that for their total population and a rate much higher than in the developed countries. At the same time, economic and social changes in these nations are eroding many of the traditional roles and support structures for the aging.

Almost half of the world's aged now live in developing nations, and this proportion is projected to increase to two-thirds by the beginning of the next century, when the majority of the world's elderly will be living in East and South Asia. Currently, however, most developing nations have relatively "young" population structures persons aged 60 and over make up less than 7 percent of the total population. In contrast, the populations of the developed nations have been aging over the past few decades. Older persons in Europe, for example, already comprise 17 percent of the total population and will reach 25 percent by the year 2025. This process is now beginning in the developing regions and will continue into the 21st century. Current projections are that the proportion of the 60-and-over population will reach 7 percent in Africa, 11 percent in Latin America and South Asia, and 20 percent in East Asia by 2025.

Developing Nations: The Needs

Because the percentage of older persons in developing nations is still relatively small and because of the scarcity of resources for all age groups policy makers in these nations have been reluctant to place much priority on the needs of the aging. Many persons who work with the aging in these

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[1] The aged population is defined as persons aged 60 and over in U.N. statistics and documentation for the World Assembly. This is simply an operational definition for comparative purposes.

nations, however, feel that not only future trends but the current situation of the elderly warrant immediate attention.

The majority of persons in developing nations are dependent upon their ability to continue working or upon family support for security in old age. As with the rural population in general, most of the aged belong to the lowest income groups—small-scale farmers, tenants, and sharecroppers. Pension coverage is generally limited to the urban sector, primarily civil servants or the military. Agricultural workers and the self-employed, who comprise the great majority of the population, remain uncovered. Workers typically do not "retire" in developing nations except as a result of disability or death.

One demographic trend with serious implications for the aged is the widespread migration by the young from rural to urban areas and even to other countries in search of employment. It is widely believed, although not well documented, that older persons are being left behind in rural areas without traditional family supports and without the physical resources necessary to continue heavy farming tasks. (It has recently been suggested that the effects of rural-urban migration on the aged are not all adverse because many migrants send money back to their families, but the long-range implications are not clear.)

Rural areas also are underserved from the standpoint of health and social services, and transportation problems make it difficult for the elderly to gain access to those services which are available. These services, primarily provided through the voluntary sector, are typically limited to the destitute and those without any family support.

Although the great majority of the aged in developing nations live in rural areas, approximately 25 percent are in urban areas, and the rate of elderly migration to urban areas is also rapidly accelerating. The urban elderly also are in a very vulnerable position. Many have no family ties and are destitute, and even those with family often live in overcrowded and unsanitary conditions—housing often designed for the nuclear family.

Income Security

Governments should make every effort to expand social security coverage to all sectors, including agricultural workers and the self-employed. Since many nations face enormous problems in financing such coverage, however, interim measures, such as cash and food assistance, should be adopted to provide some protection to the needy elderly. Nations also are encouraged to establish flexible (rather than early) retirement ages so that the burden of unemployment is not shifted primarily to older workers. Other innovative measures, such as income supplementation and generating schemes for families which support their older members, also should be encouraged.

Family Life

The family is viewed as the fundamental institution for the care of the elderly, and institutionalization as a last resort. Due to changes in family life resulting from migration and urbanization, efforts must be made to preserve and strengthen family structures and to encourage younger members to assume responsibility for the care of the aged. Measures suggested to meet this goal stressed economic incentives to families, such as tax relief and allowances. Because many persons in developing nations believe that a large number of children provides security in old age, and such attitudes are thought to influence birth rates, comparative research in this area is recommended.

Health

Emphasis is placed on integrating the aged into the primary health care system, which is the main vehicle for providing health care to the aged in developing nations. In order to ensure the health of future as well as current generations of the aged, high priority also is placed on preventive health care, and particularly on good nutrition. Because of the scarcity of public medical services and their high cost, several regions noted the continuing reliance on folk healing practices, and the need for research on how these affect the aged. Other health-related recommendations include the need for mobile clinics in rural areas, and for training community health workers in gerontology and geriatrics.

Housing and Environment

The reports of all developing regions point to acute housing shortages for all age groups. Policies need to be adopted which will assist families in improving their homes to meet the needs of the aged, and to encourage the development of cooperative housing projects for the aging.

Social Welfare Services

Several regions urge the joint development and implementation of social services by governmental and voluntary sectors, and the policy-makers in Asia and the Pacific go so far as to recommend that "subsidies should be provided from public funds to non-govermental organizations to encourage them to initiate community and family-based welfare services for the needy aged." In providing social services, emphasis should be placed on delivering services in traditional community sites where the elderly congregate, such as places of worship. The aged themselves should also be utilized as resources in the provision of social services to other needy groups, including children and the homebound.

Education

Educational recommendations stressed areas which relate to older persons' basic needs—for literacy, good nutrition, and skills which would assist them in becoming economically self-reliant. Reflecting the important role of the family in the life of older persons, strong emphasis also was placed on intergenerational education programs and educating the young about the aging process. The mass media were considered important and under-utilized tools in developing public awareness about aging.

Draft Action Plan Developed

Some of the above recommendations have been incorporated in the first draft of the "international action plan" which is to serve as a basis for discussion at the World Assembly. (The discussion and adoption of an action plan will be the most important item on the Assembly agenda.) The draft, prepared by the U.N. Secretariat for the World Assembly on Aging, was recently submitted to the second meeting of the 22-nation World Assembly Advisory Committee for review, and will undoubtedly be revised again before being presented to the Assembly itself for a final critique.

Since the "social weight" the elderly will carry as a percentage of the population in developing nations over the next decade will be negligible, it has been suggested that only a new awareness of the needs of the aging on the part of other age groups will be able to improve older persons' lot. One hope is that the World Assembly on Aging will raise the consciousness of policy-makers in these nations, where "everything is a priority", regarding their duty to alert the general public to the needs of the aging and engage in long-range planning.

Meeting the Needs in Developing Nations

Experts in aging in all regions of the world have now met in order to analyze demographic trends, assess the various developmental and humanitarian issues the World Assembly will address, and report on the conditions and status of the aging at the regional and national levels. Their conclusions and recommendations are being considered at regional meetings for policy-makers before being considered at the World Assembly itself.

Highlighted below are some of the recommendations made by experts in aging from the developing nations at separate meetings for Africa, Latin America, the Middle East and Mediterranean regions, and Asia and the Pacific, as well as those made by government policy-makers at a regional meeting for Asia and the Pacific.[2]

The Impact of Aging on Social and Economic Development

Because of increasing dependency ratios and declining productivity in rural areas, incentives should be provided to encourage younger workers to remain in rural areas. Another important need is to introduce technologies in rural areas which are adapted to the capabilities of older persons, and to provide them with training in these techniques. Participants also suggest that social security funds be used to finance development projects which could benefit the aged. Finally, the need for increased data collection and research on urbanization and the effects of migration on the aged were considered critical parts of development efforts in all regions, where the lack of such systematic data has been a serious barrier to planning.

Participation in the Assembly

Participation in the World Assembly on Aging will be limited to official representatives of the member nations of the U.N. and to representatives from U.N. organizations. There will be some room for others as observers primarily the press, international voluntary organizations accredited to the *Economic and Social Council of the U.N.*, and some national voluntary organizations active in the field of aging which are considered to have expertise transferable to other countries. Nevertheless, it is likely that numerous organizations registered by the U.N. will have difficulty finding seats because of severe space limitations in the Hofburg Palace.

The primary opportunity for representatives from nongovernmental organizations to express their views was the Forum of NGO's on the World Assembly on Aging, held March 29 to April 2 in Vienna. The conclusions of this Forum, which was co-chaired by the Centre International de Gerontologie Sociale and the International Federation on Ageing, will be made available to the drafters of the World Assembly documentation, and also will be presented to the World Assembly.

Representatives of voluntary organizations will have an opportunity to participate in informal "ancillary" meetings being organized by selected international voluntary organizations in Vienna at the time of the World Assembly itself. These meetings will focus on various aspects of the international action plan and the role of voluntary organizations in the plan's implementation. They may also serve as a informal link between the nongovernmental sector and the governmental delegations at the Assembly.

Issues Which May Evoke Controversy

In general, the question of aging is one with few political overtones, and, to date, the various preparatory meetings have been relatively free from political controversy. Nonetheless, the World Assembly itself will be an intergovernmental meeting, and delegates will, of course, be instructed to support their nation's overall policies. Because of variations in the economic, political, and social structures of the nations represented, as well as their resources and priorities, arriving at one global document will be a difficult and, no doubt, controversial task.

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[2] Regional meetings of experts in aging were held for North America and Europe in June, 1981. Regional meetings for policy-makers were held in Africa, Latin America, and Europe in March and April, 1982.

Some differences of opinion have been forecast by the discussions of the *Advisory Committee* on several issues, and these differences may surface at the Assembly itself. One likely major issue will be whether or not to establish a separate agency within the U.N. to help implement the international action plan. Both the U.S. and the U.S.S.R. are opposed to establishing another U.N. bureaucracy, but some delegates from developing nations may well favor such a move. The U.S. proposed, instead, that the present Centre for Social Development and Humanitarian Affairs be upgraded to a branch level with authority to deal directly with U.N. specialized agencies concerning projects related to the implementation of the action plan. The U.S. is also suggesting that the U.N. Trust Fund established for the World Assembly be continued after the World Assembly in order to assist developing nations in implementing the action plan.

Some countries are also sensitive about plans to monitor the implementation of the action plan following the Assembly for fear this might infringe on national sovereignties.

A few of the developing countries are concerned about wording regarding the expansion of social security benefits and employment opportunities to the elderly. They wished to add qualifying language to take into account their more limited resources, the protection afforded by their traditional family systems, and the needs of the unemployed young.

U.S. Role in the Assembly on Aging

The U.S. introduced the General Assembly resolution which authorized the draft Assembly and has been the largest contributor to the U.N. Trust Fund for the World Assembly on Aging. An American, William Kerrigan, the former General Secretary of the International Federation on Ageing, was appointed Secretary-General of the World Assembly on Aging. His appointment is particularly significant because it represents the first time that an American has been selected to head a world assembly, and the first time that such an individual has been appointed from the nongovernmental sector.

The U.S. delegation to the World Assembly on Aging, soon to be appointed by President Reagan, will be small, and will principally include officials from interested government agencies and members of Congress. U.S. preparations for the Assembly are being coordinated by Ambassador John McDonald of the U.S. Department of State, assisted by an interagency task force and an advisory committee of national voluntary organizations and others from the private sector active in aging and related fields.

Hopes for the World Assembly on Aging

The World Assembly has great potential for inspiring some positive changes in national policies which directly affect older persons. There are good grounds for hoping that it will encourage nations to institute or expand programs for the elderly. Perhaps most importantly, the World Assembly has a powerful "consciousness-raising" value. It is a direct statement to governments that they can no longer ignore either the needs of the aging or the impact of the aging of their population in social and economic development.

Already, the regional preparatory meetings of experts have brought together a wealth of previously fragmented knowledge about the situation of the aging on the national and regional levels, and, in the process, identified specific gaps in knowledge and targeted areas for future research. Further, the World Assembly on Aging has spurred the specialized agencies of the U.N. to devote greater attention to the aging in their programming and research activities. The kind of interchange which the World Assembly has already inspired in its preparatory activities among governments and among gerontologists and service providers to the elderly around the world may itself be one of its most important outcomes.

Some resources which will help interested persons learn about developments on the World Asssembly on Aging and learn more about aging in other countries are: Information Officer, World Assembly on Aging, DESI/DPI, Room 1061, United Nations, New York, NY 10017, Telephone: (212) 754-6870 and the Editor *Ageing International*, International Federation on Ageing, 1909 K Street N.W., Room 512, Washington, D.C. 20049.

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Experience Exchange

Novel Exercise Game

Since the beginning, man has sought to extend his span of years on earth and to improve the quality of life. Now a San Francisco-based fitness company is using creative techniques to enhance some old concepts regarding exercise to benefit the elderly.

With the help of health care and medical professionals, the Gamefield Concept Company in California set out to develop a walking exercise game that was easy to perform and fun to negotiate, designed especially for seniors and sedentary adults. The Conversation Pace Gamefield is an outdoor series of equipment and instructional signs which guide seniors through a novel trail sprinkled with 15 stretching, breathing, and flexing games geared to encourage and invite participation by older adults. Each of the games along the path provides a mild activity which loosens muscles, calms nerves, and enhances the health of the individual in a pleasant outdoor environment. The program is popular because it appeals not only to the need for regular walking to improve fitness and health, but provides a social meeting place, a novel walking game, and a platform for toning seldom used muscles which will aid elders in becoming more active.

The 15 stations are accompanied by an illustrated sign which coaches players in the proper method of performing each exercise. The signs all have three different exercise levels to cater to individuals at all fitness levels and provide the incentive to achieve eventually the challenge of Gamefield at its most competitive level, Playing for Competition.

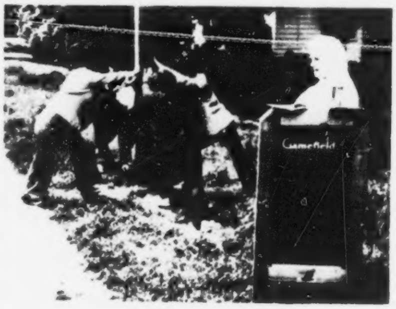
Wells Fargo Bank of California created a grant program to provide the Conversation Pace Gamefield for seniors in parks throughout the State. Currently, 45 sites are open to seniors across California in cities from San Diego to Paradise with 50 new sites opening in the next 6 months. Wells Fargo plans eventually to help fund Gamefields for seniors in every city in California where there is a need. Several banks and corporations in other states are looking into the same sponsor plan. Wells Fargo developed the Gamefields "as a continuing sign of Wells Fargo Bank's commitment to the health and vitality of all who share their services."

The Wells Fargo Gamefield costs $6,000 plus tax and freight, which includes all 15 stations ready for assembly and installation, illustrated game signs, a main introduction sign, and a fitness package to set up and operate the Gamefield. Fitness materials include the 12-week Walking Guide, a booklet which explains pertinent facts on fitness walking, heart rate, and blood pressure. Wells Fargo is providing funding to Parks Departments, as well as senior housing and schools, "according to need, commit-

ment, and desire to provide the program for all seniors to be aware of and use," says Diane Miller, director of the program for Wells Fargo Bank.

According to the Gamefield Concept company, cardiovascular failure claims over a million people each year, but regular walking can reduce the risk to a considerable degree. Current research supports the premise that regular walking can furnish 90 percent of the benefits of jogging and can actually increase the size and pumping capacity of the heart.

Mrs. Miller observes: "As you walk from game to game, you provide an opportunity for your heart to pump more blood through the body. Although it won't interrupt your conversation, gradual strengthening of the heart is taking place. If you continue your walks at a vigorous pace for 20 to 30 minutes a day, the results can be amazing. Your heart will grow to the point of pumping more blood per beat and it will operate more efficiently throughout the day. At the same time, your cardiovascular system, which includes your heart, lungs, arteries, and blood vessels, will develop better endurance while gradually reducing the effects of sedentary living. Your stamina will increase also, providing extra energy for whatever you chose to do."



Wells Fargo Bank notes that each game along the walk was designed to entertain while toning and energizing the frame. The senior can improve or extend his grip, and increase his skills in everyday tasks. The first few games along the Gamefield stretch and warm the body in preparation for activity, and gradually the activity level increases. At the midpoint of the program, the participant is kicking, twisting, and enjoying continuous movement in a surprisingly simple sequence of activities. At the approach of the final games, a gradual reduction in motion takes place leaving the body cooled down.

The Gamefield was designed by medical professionals specifically for mature adults, is endorsed by the Arizona Heart Institute, and sponsored across the country by the American Heart Association.

The 15 individual illustrated game signs for each exercise station are made of indestructible lexan and can be placed in almost any setting to adapt to any landscape environment. For wide open spaces, games may be located over a mile or more offering the necessary walking between stations. For compact urban environments, a court concept, which allows all 15 stations to fit in an area no longer than 30 feet by 40 feet, is available, as well as other configurations for limited grounds. The Gamefield kit arrives with assembly and installation instructions.

Comments from Gamefield participants in California are uniformly enthusiastic. Irene Baranski comments: "After a summer on the Gamefield I find that I have a lot more energy and my right shoulder, which used to hurt terribly from arthritis, isn't so bad anymore."

Alice Nevermann notes: "It calms my nerves. I think it's very relaxing. I live alone and that can get lonely. Gamefield is a healthy way to get outdoors, enjoy the fresh air, and make friends. That's why I like it."

Pam Lehman, a Gamefield instructor, points out: "I think the Gamefield is important because it encourages seniors to get involved in regular exercise. I've seen over the period of our class new friendships being made and a lot of fun and good spirit. Also, almost everyone comes at first thinking they can't do many of the games and, one by one, someone breaks the barrier and soon everyone is succeeding. The encouragement is tremendous and everyone enjoys themselves."

Further information on the Gamefield is available from:

The Gamefield Concept
Wells Fargo Grant Program
2088 Union Street
Suite One
San Francisco, Calif. 94123
Telephone: (415) 563-2805

Senior Survival Services

A Phoenix liquor store owner drove all night to his elderly mother's house in Ventura County, California, after he received a confused phone call from her in the middle of the night. A Washington, D.C. man became panicky when his mother, who had been feeling very tired for several weeks, failed to answer his weekly 9 a.m. call to her after Mass; and an Oregon widow became increasingly upset when regular letters from an old friend in Ventura County stopped coming, and the operator said the phone was disconnected.

Fortunately, all three of these people already knew, or soon learned, about a unique program in Ventura County, called "Senior Survival Services." Relatives or friends living anywhere in the U.S. who are worried about an elderly person living in the county can call the service, and one of four "survival workers" will check on the older person and report back to the relative by phone, usually within an hour.

The survival workers, two of whom are employees of the public social services agency, cover the entire 2,000 square mile county, and, through a beeper system, can be contacted at any time of the day or night. If there is a problem at the home of the senior citizen, the survival worker doesn't leave until it is solved, whether it be lack of food or medicine or a leaky roof.

The Phoenix man found out, after shouting and banging on the window to rouse his mother, that she had taken medication for a cold and a sleeping pill and had phoned him in a drowsy, dream-like state. Before starting back to Phoenix, he stopped in a local diner, and a waitress who listened to his story advised him to contact Senior Survival Services to avoid a similar traumatic experience in the future.

The Washington, D.C. man learned about the service from the police who said they were handling an emergency and couldn't check on his mother for a couple of hours. He called the service, and, within 20 minutes, found out that his very apologetic mother had lost track of the time in chatting with a new friend after church.

The Oregon widow had received a flier describing the survival services from her Ventura friend several months before to use in case of an emergency. Discreet inquiries by a survival worker revealed that the friend, as the widow feared, had been gradually cutting herself off from the world, requesting disconnection of her phone and neglecting to write. The Oregon lady was greatly relieved by the call from the survival service but decided to drive down and spend several days with her old friend.

According to 78-year-old Tony Lamb, the dynamic senior citizens' coordinator for Ventura County, long-distance relatives and friends are not the only ones who call Senior Survival Services. Apartment managers, electricians, meter readers, and neighbors also contact the program when they suspect a senior citizen is in trouble.

If the senior's problem is serious, the survival worker has access to another unique resource in Ventura County—a "Senior Survival Emergency Fund" which can hand out money or a check as an outright gift to rescue seniors with urgent financial problems. Sometimes a social security check is lost or a senior faces eviction from a rooming house or shut-off of heat or electricity due to nonpayment of a bill.

In a pre-Christmas letter sent one year to prospective emergency fund donors entitled "No Room at the Inn, No Food on the Table, No Money In the Pocket," Lamb noted that, based on six years of experience, he could predict the kind of calls he would receive during the holiday season. "A motel manager," he wrote, "will phone that there is an old woman, probably sick, without food or medicine, and that she will have to be evicted by 12 noon since she can't pay her bill . . . or the police will phone that a senior is sleeping in the park . . . because his December 3rd Social Security check didn't arrive."

There is plenty of money in one pocket or another. You can always get money or volunteer help if you try.

Operated under the auspices of the Ventura County Council on Aging, the emergency fund is supported totally by donations—ranging from small contributions from local high school classes and Kiwanis clubs to a $500 anonymous cash gift and a $2,000 check from a New York City foundation.

While the emergency fund relies on donors, another special service for seniors in Ventura County—"Survivalmobile"—draws on city and county Revenue Sharing funds of $1 per senior per year. Operated by the public social services agency, Survivalmobile makes use of 41 senior or mature drivers who provide emergency transportation to older residents of the county. Paid $2.95 an hour, plus 28¢ per mile, the drivers are available to help seniors who have not been able to solve their transportation problems through the usual channels.

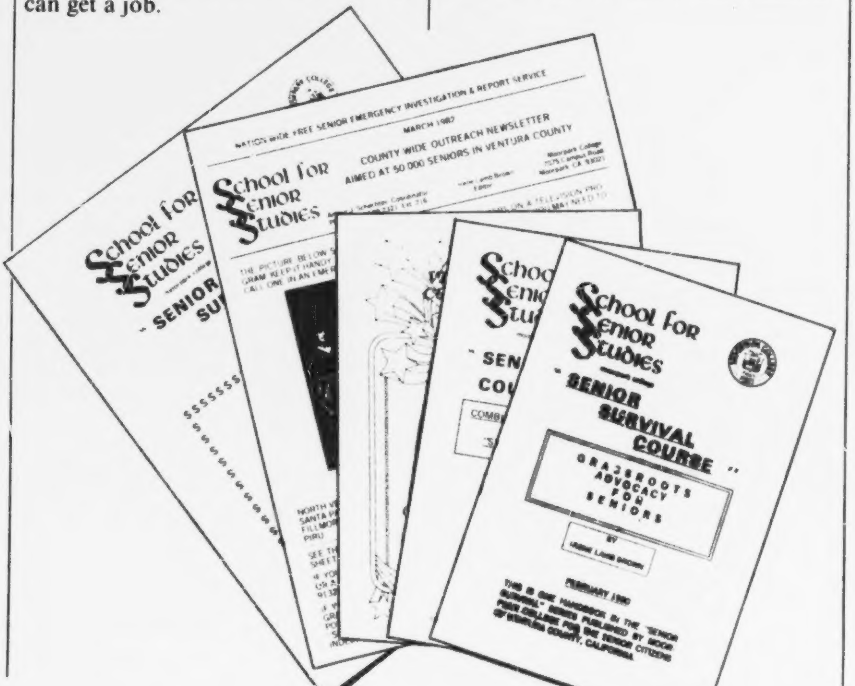
Survivalmobile arranges about 30 rides a day, usually short trips to medical clinics, doctor's appointments, the

Social Security Office or for emergency shopping. "But we gave one lady a 60-mile ride to a hospital for a cataract operation, and another woman with asthma receives regular rides to a county hospital for lung treatments."

"The drivers do more than just drive," points out Lamb. "They take the senior up to the right floor in the hospital, and they tell the nurse, 'I'm here with Mrs. Smith, and I'll wait.' "

The unusual array of services available to Ventura County seniors would not be complete without a mention of the "Senior Survival Courses" that started out at Moorpark College, but are now beamed via radio and cable TV to an estimated 20,000 seniors and an equal number of younger residents who care for an elderly person.

The course, hosted by Lamb, who often invites experts to speak, covers everything seniors need to know to survive in what the brochure calls "the maze of agencies that control their lives." Topics covered include recent changes in social security, welfare, and food stamps; Supplemental Security Income; "What Every Veteran Ought to Know;" and how a senior of any age can get a job.


School for Senior Studies
NATIONWIDE FREE SENIOR EMERGENCY INVESTIGATION & REPORT SERVICE
MARCH 1982
COUNTY WIDE OUTREACH NEWSLETTER
AIMED AT 50,000 SENIORS IN VENTURA COUNTY
SENIOR SURVIVAL COURSE
GRASSROOTS ADVOCACY FOR SENIORS
FEBRUARY 1980

"Sometimes I tell seniors what they should do during that particular week — like getting their renter's refund form filled out, applying for energy assistance money, or taking advantage of free glaucoma tests." More than 30 handbooks and guides on the topics covered in the half-hour radio and TV shows are also available free to listeners and viewers on request from Moorpark College.

"Last week," notes Lamb, "I had the man in charge of social security in the county on the show and he assured people his office would always be open to seniors in need of help. I want to break down the barriers between big officials and frail seniors."

Lamb also takes the TV cameramen to the homes of seniors with fascinating hobbies and skills and does interviews with "Living Pioneers." "I recently interviewed a man who went through the San Francisco earthquake," Lamb explains, "and another senior who was involved in development of the first X-ray machine."

"What I do on radio and TV," continues Lamb, "is to cover everything seniors ought to know and whatever may give them happiness or new direction."

Lamb says when he first started the course, he went to two radio stations and talked them into giving him free time at 7 a.m. before regular programming begins.

Always ingenious at finding an answer to a problem, he and other seniors also trained four volunteers, including a county supervisor, to take over the duties of a survival worker when her job was abolished due to lack of county funds. Then Lamb and his colleagues went to the city council in Thousand Oaks and pleaded with them to reinstate the original worker, using city instead of county funds. Four volunteer workers, they argued, just couldn't provide the necessary continuity in the job. The council listened and agreed to pay the survival worker's salary.

Appointed by Governor Brown in 1977 as a member of the State Commission on Aging and invited to the White House by former President Carter in 1980, Lamb is very proud of what Ventura County offers its seniors.

"There is plenty of money in one pocket or another. You can always get the money or volunteer help if you try," Lamb asserts, before launching into a description of other unique Ventura senior programs — including the "Skill Bank" file listing of 6,000 retired people willing to volunteer plumbing, electrical, sewing, and other services to seniors in need; "Buddy Phonemates" that matches seniors who phone each other daily and form lasting friendships; and "Live-In Exchange." . . .

"I believe in senior's doing all they can for one another," concludes the indefatigable Lamb whose address is:

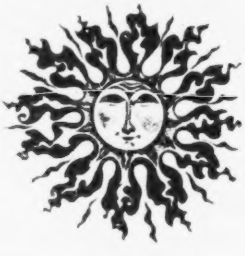
Tony Lamb
Senior Citizen's Coordinator
Ventura County Council on Aging
3161 Loma Vista Rd.
Ventura, Calif. 93003
Telephone: (805) 694-3678

Course and Conference Calendar

June

June 1-10. Second Annual Summer Institute on Aging at Kean College of New Jersey, Union, N.J. Robert A. Famighetti, Kean College Gerontology Center, James Townley House, Union, N.J. 07083 (201) 527-2605.

June 7-18. Summer Institute (Session I) at North Texas State University. Eleanor Adams, Center for Studies in Aging, P.O. Box 13438, NT Station, North Texas State University, Denton, Texas 76203 (817) 788-2763.



June 21-July 2. Summer Institute (Session II) at North Texas State University. Eleanor Adams, Center for Studies in Aging, P.O. Box 13438, NT Station, North Texas State University, Denton, Texas 76203. (817) 788-2763.

June 30-July 2. "Improving Protective Services for Older Americans" at the Gorham Campus of the University of Southern Maine. Kate Oliver, Human Services Development Institute, The University, 246 Deering Ave., Portland, Maine 04102. (207) 780-4430.

July

July 5-16. Summer Institute for Study in Gerontology (Session I) at the University of Southern California. Leonard Davis School of Gerontology, Ethel Percy Andrus Gerontology Center, University of Southern California, P.O. Box 77912, Los Angeles, Calif. 90007. (213) 743-6060.

July 5-July 16. Summer Institute (Session III) at North Texas State University. Eleanor Adams, Center for Studies in Aging, P.O. Box 13438, NT Station, North Texas State University, Denton, Texas 76203. (817) 788-2763.

July 12-23. Summer Institute on Aging for Extension Professionals at the University of Missouri at Columbia. Summer Institute on Aging, Center for Aging Studies, 323 Lewis Hall, The University, Columbia, Mo. 65211. (314) 882-6011.

July 19-30. Summer Institute (Session IV) at North Texas State University. Eleanor Adams, Center for Studies in Aging, P.O. Box 13438, NT Station, North Texas State University, Denton, Texas 76203. (817) 788-2763.

July 19-30. Summer Institute for Study in Gerontology (Session II) at the University of Southern California. Leonard Davis School of Gerontology, Ethel Percy Andrus Gerontology Center, The University, P.O. Box 77012, Los Angeles, Calif. 90007. (213) 743-6060.

July 20-22. Eighth Annual Benefit Plan Administrators Institute. "The Future of Employee Benefits In a Deepening Recession." At the Lake Shore Drive Holiday Inn, Chicago, Ill. Charles D. Spencer & Associates, Inc., 222 West Adams St., Chicago, Ill. 60606. (312) 236-2615.

August

Aug. 2-13. Summer Institute for Study in Gerontology (Session III) at the University of Southern California. Leonard Davis School of Gerontology, Ethel Percy Andrus Gerontology Center, University of Southern California, P.O. Box 77912, Los Angeles, California 90007. (213) 743-6060.

Aug. 28-Sept. 1. The Next Challenge: Coming of Age Under the New Federalism. Training Conference of the National Association of State Units on Aging and the National Association of Area Agencies on Aging at the Marriott Hotel in Denver, Colo. NASUA/N4A Conference Coordinator, 600 Maryland Ave., S.W., Suite 208-West, Washington, D.C. 20024. (202) 484-7182.

September

Sept. 28-30. "Meeting the Challenge, Fewer Resources, Greater Needs." In Dallas, Tex. Southwest Society on Aging, P.O. Box 55125, Hillcrest Station, Little Rock, Ark. 72205.

October

Oct. 1-2. "Frontiers in Medicine: Implications for the Future." At the Hilton Hotel, Beverly Hills, Calif. Health Sciences, UCLA Extension, P.O. Box 24901, Los Angeles, Calif. 90024. (213) 825-8421.

Oct. 21-22. Second Annual Conference of the Hawaii Pacific Gerontological Society at the New Tapa Tower, Hilton Hawaiian Village, Honolulu, Hawaii. Hawaii Pacific Gerontological Society Conference, P.O. Box 3714, Honolulu, Hawaii, 96812.

November

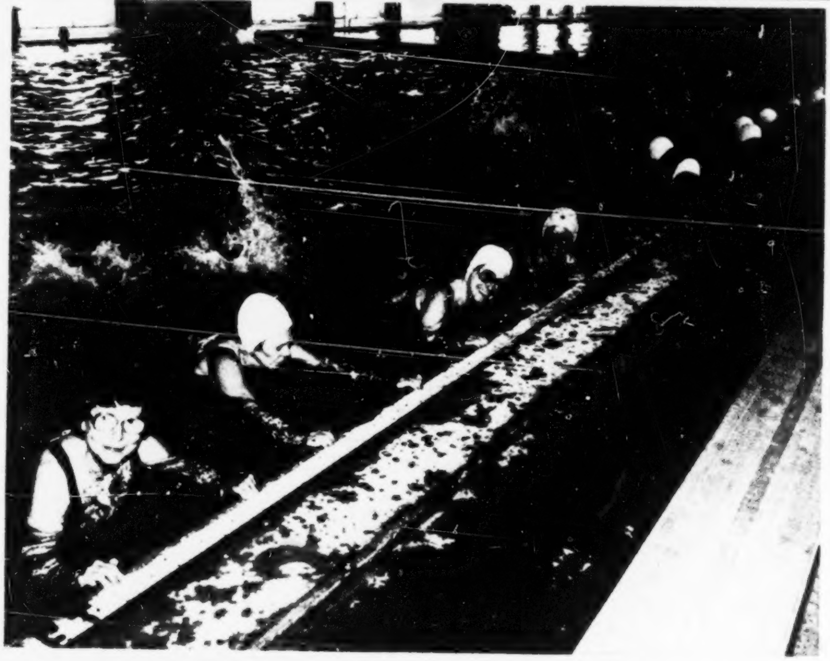
Nov. 19-23. Annual Meeting of the Gerontological Society of America. Sheraton-Boston Hotel, Boston, Mass. Gerontological Society's Central Office, 1835 K Street, N.W., Suite 305, Wash., D.C. 20006. (202) 466-6750.

February

Feb. 23-25. Second Annual Elderly Offender Conference at Florida International University in Miami, Fla. Dr. William Wilbanks, Department of Criminal Justice, The University, AC-I-284, N. Miami, Fla. 33181. (305) 595-6102.

State and Community News

Taking the Plunge To Get Back In Shape



For too many people, swimming is an activity vigorously enjoyed in childhood that is reduced during the middle and older years to a quick "dip" in the hot summer sun.

Not so for a group of 425 elderly men and women from Rhode Island who have taken the plunge by enrolling in year-round acquatic exercise classes conducted in local pools by the state's Department of Elderly Affairs.

Legs thrash, knees get drawn up to the chest and stretched out, and muscles are toned to the rhythmic clapping and encouragement of the program's enthusiastic instructor Delores Bergeron.

A 15-minute warm-up period loosens up body and spirit, and after the acquatic exercises, seniors get a half hour of free swimming or movement to enjoy that new feeling of muscles working smoothly and well.

Mrs. Bergeron says seniors in the classes tell her they "feel great, sleep better" and experience a general sense of well-being.

"A lot of older people aren't getting enough exercise," comments Bergeron. "I'm not concerned with those who play golf or go bowling. I'm concerned with those who are content to sit at home, or go to a center and sit, or go on trips and come home and sit."

One 79-year-old participant, who has been coming to the twice weekly classes for two years, says she's lost weight and sleeps a lot better because of the exercise. She thinks all older people should exercise more — even at 79 years old. "If they don't, they're crazy. They'll feel better if they do," pronounces the spunky lady who not only participates in the exercises but plays water basketball, too.

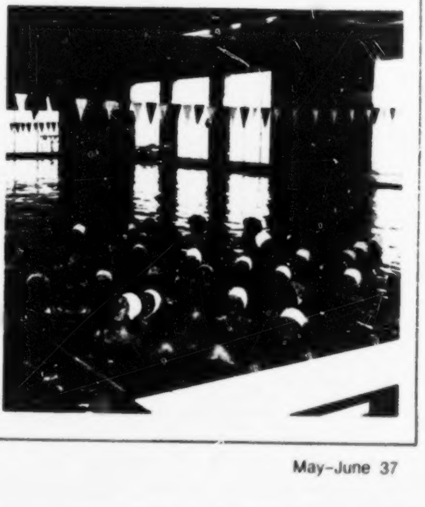
Both swimmers and nonswimmers 60 and over are eligible for the Senior Citizens' Pool Program (the oldest participant is 92). The emphasis is on exercise, not on learning to swim, and seniors don't have to be at any particular level of physical condition to participate. Some pools charge a small admission fee for each session, but there are no membership fees.

According to Mrs. Bergeron, who started the program in 1979 by asking local pools to set aside special time for the elderly, the program's success is partly due to its minimal cost. "It sure beats expensive health clubs," says the 48-year-old instructor. "And doctors have said there isn't anything more beneficial to good health than swimming."

In fact, many participants report that the water exercises have resulted in significant improvements in arthritic conditions, back pains and hip problems.

A Warwick, R.I. resident claims the exercises have been the best therapy for her double hip operation and the recurring pain in her shoulder. "The pain has disappeared," she says. Another 67-year-old woman, stricken with arthritis, walked with considerable difficulty when she joined the program. One year later, she was walking normally, and attributed much of the improvement to the exercises in the pool.

Mrs. Bergeron acknowledges that there's no cure for arthritis, but says the water exercises can prevent the disease from spreading to other parts of the body.



"It's easier to do exercises in the pool," notes Bergeron. "You don't feel any pain because the water takes up 90 percent of your body weight." The water weight, for instance, of a person who weighs 135 pounds would be 13 pounds in the pool, the instructor explains.

The Rhode Island pool program is not only physically therapeutic. It has many social and recreational benefits as well. A Warwick widow comments: "When I lost my husband, the Pool Program got me out of the house." Others talk enthusiastically about the new friends they have made and the new perspective the twice weekly swimming sessions have brought to their lives.

For further information, contact Mrs. Delores Bergeron, Physical Fitness Coordinator, Rhode Island Department of Elderly Affairs, 79 Washington St., Providence, R.I. 02903.

Seniors Go Back To High School for A Day In Livingston, N.J.

Senior citizens and teenagers in Livingston, N.J. compared notes on how things had changed over the years when they spent an exciting morning attending classes together last fall at the local high school

A few eyebrows were reportedly raised over the current make-up and blue jeans worn by contemporary teenagers by elderly ladies remembering their own school days. But, in general, the senior visitors said they were impressed by the informality of the classrooms, the easy interaction between students and teachers, and the quality of the material being taught.

The pages of history books came alive for students and older people fortunate enough to be in several classes taught by senior citizens who volunteered to be guest lecturers. According to one observer, a senior who was a spy for the U.S. in World War II held history classes spellbound describing his adventures in France prior to D-Day. In another class, several older residents whose parents were immigrants from Eastern Europe recounted early experiences that illustrated the difficulties and joys of being an immigrant in the United States.

Other seniors shared current passions and enthusiasms, including a beekeeper who gave a graphic demonstration of the biological relationship between bees and people by allowing one of his bees to sting him.

But more important than the factual and historical information exchanged were the new perceptions the teenagers and the elderly developed of one another. A teenager remarked that "it was a pleasure to sit and talk with an older person on an equal basis," and to see that "the senior was really interested in what I had to say."

Noting the many disturbing stories that the older generation hears about what goes on in high schools today, one elderly resident commented: "We were pleased to learn first-hand that most of those stories weren't true for our high school."

The "Learning Together" program at Livingston high used a buddy system to encourage one-to-one contact between students and seniors. During the week before the special program, each elderly participant was called by his student buddy to confirm details of the morning's activities. On the day of the program, the student buddy escorted the older adult to classes and later sat with the senior at a special "intergenerational" lunch. Mid-morning coffee and cake were also served in the school library to allow for additional informal contact between the teenagers and the elderly.

The program drew more than 70 senior citizens, including some who had never participated in other types of senior activities in the comunity. "Learning Together" was carefully planned by the Livingston Township Advisory Council on Senior Citizens, a volunteer group, and teachers and staff at Livingston High. For weeks prior to the event, the local newspaper featured stories on the program, and students and senior organizers spoke to local senior citizen groups.

A bulletin also went out to senior residents inviting them to register for the particular classes they would like to attend. Registration included a small fee for the luncheon, because the program's organizers thought a prepayment would indicate a firm commitment to attend.

According to Livingston Senior Citizen Coordinator Roberta Schoenberg, the idea for the "Learning Together" program was sparked by an observation made one day by an elderly resident. Complaining about the usual activities offered to seniors, the resident said: "Too many programs for senior citizens are like TV. They treat us like passive observers. We still have active minds and years of experience. Of course, we want to learn new things but we also want to share our acquired skills, our educational training and our life experiences with other age groups. We don't want to be just entertained—we want to participate."

For further information, contact: Roberta Schoenberg, Senior Citizen Coordinator, Town Hall, 357 South Livingston Ave., Livingston, N.J. 07039.

Third Graders and Their "Adoptive" Grandparents

Several months ago, Karen Lilienkamp, director of Older Adult Services in West Milford, N.J., began worrying about a problem common to many communities—lack of interation between children and the elderly.

The problem, however, is more acute in West Milford, since the township is a semi-rural area covering 87 square miles where the elderly often find themselves more isolated than seniors living in the city.

Mrs. Lilienkamp says the seniors either have no children of their own or their sons and daughters typically have moved away to marry and settle down in New York area suburbs, too far to permit frequent visits between grandchildren and grandparents.

While the elderly are lonely due to their departing families, many of the young couples moving to town are raising children far from grandparents.

"I became aware," says Mrs. Lilienkamp, "that a fair number of the children in my daughter's third grade class do not have grandparents living nearby." This observation started her thinking about how she could involve the third graders and the elderly in one another's lives.

"We began by having the children make cards, posters, and murals for seniors hospitalized or homebound due to illness," explains the adult services director.

This was such a success that the fourth graders were enlisted to practice their writing and social skills by sending regular letters to some of the elderly residents who come twice a week for meals at the senior center. The seniors, of course, returned letters to their "adopted grandchildren," and a relationship between them started via the mail.

The next step, naturally, was for the seniors to visit the Marshall Hill Elementary School, and they now attend tea parties with the children and exchange birthday cards. Each child continues to send something to his or her "adopted grandparent" at the end of the week—a letter, a drawing, or even a composition or test paper that the student is particularly proud of.

The elderly also take turns going to school to talk to the children about what it is like to be an older American and to share stories and photographs with them showing what life was like years ago.

"It's amazing how attentive the children are," comments Mrs. Lilienkamp. "Due to the overwhelming joy this program has brought to all participants, we have been invited to begin a similar program in two other shcools." For information you may write or call: Karen Lilienkamp, Director of Older Adult Services, West Milford Department of Parks and Recreation, 1480 Union Valley Rd., West Milford, N.J., 07480 (201) 728-7979.

Nursing Home Residents Build A Float For A July 4th Parade

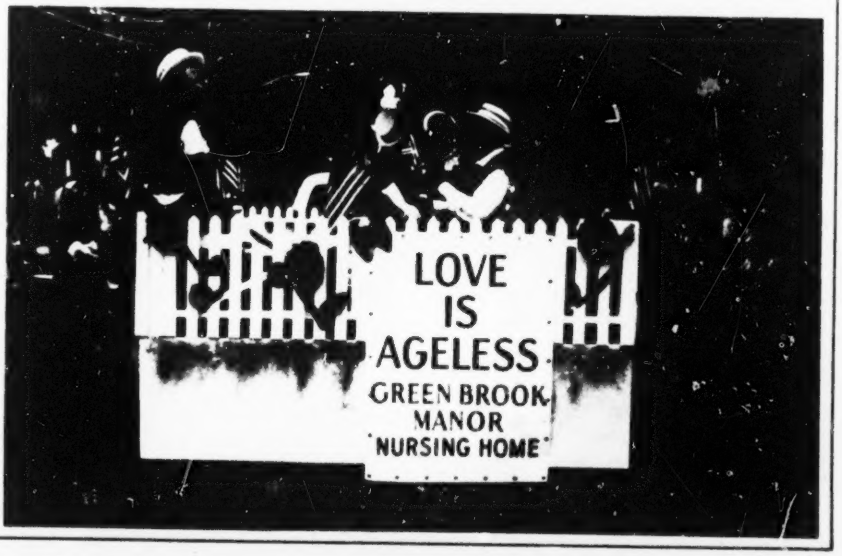
For years, the Independence Day parade down the main street of Plainfield, N.J., attracted the usual participants—high school bands, politicians, and local service clubs.

But last July 4th, a new group joined the line of march—residents who are rarely invited to take part and be visible in important community events.

Singing and playing an upright piano atop a float decorated with picket fencing and red and white paper flowers were several elderly residents from Greenbrook Manor Nursing Home. Decked out in red, white and blue, they sang patriotic songs to the lively accompaniment of their piano player, a retired musician, and the rhythmic flag-waving of two young summer volunteers.

Residents from Greenbrook Manor helped to make the colorful decorations that turned a flat-bed agricultural trailor into a stand out attraction in the 3-hour parade. Greenbrook won a trophy for their efforts and undoubtedly a regular spot for the nursing home in Plainfield's Independence Day events. At least, plans are underway right now for a float for this year's parade with an entirely new motif.

Nursing home residents participate in a July 4th parade? Greenbrook Manor residents say if they accepted the invitation and the challenge, nursing homes in other communities can do it, too. For information please write or call: Ruth Bannon, Greenbrook Manor Nursing Home, 303 Rock Ave., Green Brook, N.J. 08812 (201) 968-5500.



Love Inc. Lives Up To Its Name

Four years ago, Dr. Virgil Gulker began an innovative helping services concept at the Good Samaritan Center in Holland, Michigan, which he aptly entitled Love, Inc. The program coordinated the efforts of 13 public and private service agencies and involved 74 area churches in the center's work with the needy. By coordinating the agencies' services, duplication was reduced and agency responsiveness was increased.

The 74 LOVE Inc. churches in a four city area including Holland, Zeland, Douglas, and Sangatuck were organized to assume responsibility for needs that originated in their designated church zone. Acting on referrals from the Good Samaritan Center, contact people from the churches harnessed their resources volunteers and material assistance to respond to 377 individual and family needs in 1980. LOVE Inc. churches are now offering major projects and activities for senior citizens and others which have traditionally been offered at greater expense by tax-supported agencies.

LOVE Inc. has provided chore services and telephone reassurance to those seniors who would otherwise have to enter a nursing home; errand or shopping services for shut-ins; assistance in preparing tax, social security, or medical forms; companionship, activities, and guardianship services for nursing home residents; as well as emergency rent, fuel or utility assistance for low-income seniors. LOVE Inc. church resources have also been used to meet seniors' food, clothing, and transportation needs.

LOVE Inc. was the product of practical necessity. Senior citizen populations and needs are increasing at a faster rate than the resources available to meet them. Agencies, whether supported by dwindling tax dollars or unpredictable charitable contributions, often cannot keep pace with the expanding demand for their services.

"Yet within each community there is at least one church, with its own community of caring people who possess the time, resources, and skills to alleviate many of their needs. Multiply that by the number of churches in a community and you have a helping network with the potential to reduce significantly mental, physical, spiritual, and emotional needs. All that is needed is an organization plan to harness and direct that vast, largely untapped resource. LOVE Inc. provides that organization," says Dr. Gulker.

LOVE Inc. became a reality in two simple steps. First, the Center divided the city of Holland and surrounding areas into 20 church zones, and churches were assigned to the zones in which they were located.

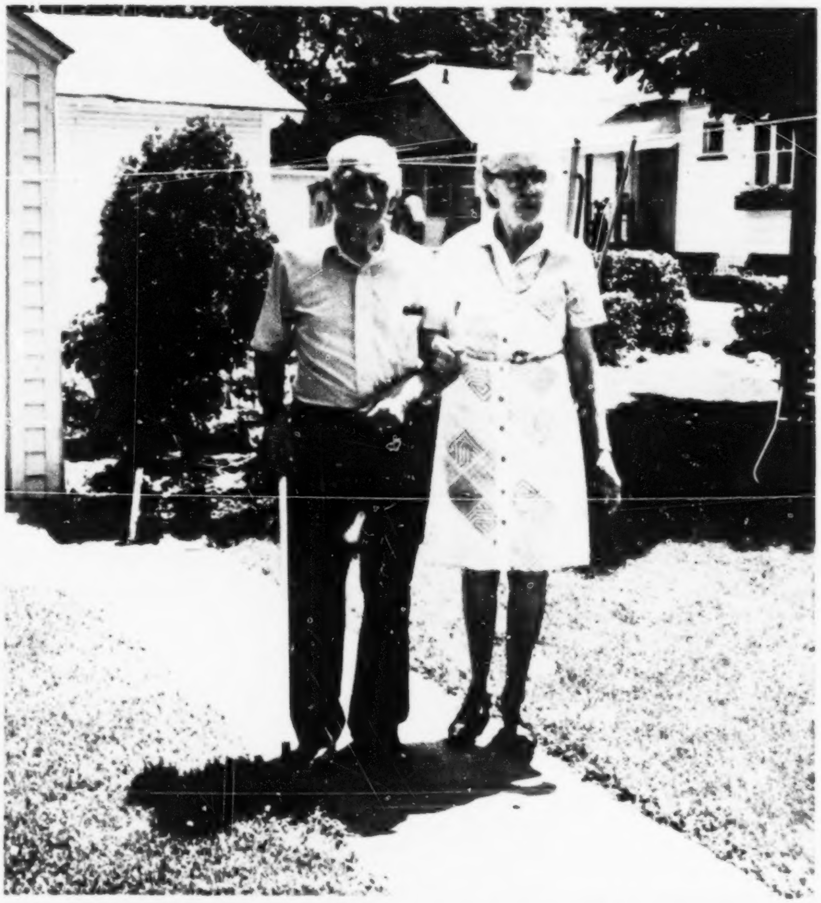
Second, the Center presented the LOVE Inc. program to the area pastors. They were told that LOVE Inc. churches would assume responsibility for the needs which originated in their church zones. Non-specialized needs would be referred to designated contact people in the zone churches, while the Center would refer cases involving health care, substance abuse counseling, psychiatric care and other specialized needs to appropriate agencies.

The contact people would draw on the resources—volunteers, clothing, furniture, money—of their churches to meet most needs. The Center would then follow up with the church contact person and the individual in need to determine the value of the helping experience for both the client and the volunteer. Seventy-four pastors said an emphatic "yes" to the LOVE Inc. program.

As Margaret, a visually impaired senior citizen who lives on SSI, discovered, the LOVE Inc. referral procedure works quickly and effectively. Margaret asked the Center to help her find an occasional companion who could assist her with errands and shopping. Mindful that her four children would refuse to help her, the Center alerted the contact person in her church zone. The church located an 18-year-old girl who became Margaret's friend.

The American Cancer Society, the Public Health Department, the Department of Social Services and other agencies have also discovered that LOVE Inc. is a valuable community resource. These agencies have asked the Center to recruit church volunteers to provide a wide variety of senior services, including transportation for cancer or kidney dialysis patients to a hospital located 30 miles from Holland—not once or twice, but 30 times. Yet the churches have never failed to provide this service and most have refused compensation for mileage.

The Center also used the LOVE Inc. churches to offer various projects and activities, many for seniors. Shelter care for abused spouses, escort and guardianship services for nursing home residents, and a luncheon club for adult foster care home residents are just a few of the organized services provided by churches. The commitment of church members to project ministries became apparent recently when one LOVE Inc. church financed structural modifications in their facility so that a Club for Stroke Patients could meet there.



The value of LOVE Inc. for seniors lies less in the services churches can provide than in the quality of those services. Unlike public agency employees, church volunteers are not saddled by unmanageable caseloads; nor are they obliged to process needs routinely in the impersonal manner prescribed by law or departmental regulations. Church volunteers provide personalized assistance. They can take the time to know and understand the seniors, and they can fashion those caring relationships which help the elderly rediscover their dignity and self-esteem. Seniors in the four city area are learning that church volunteers view their needs as opportunities for service which often means as much to the volunteers as to the senior citizens.

In the future, churches will be asked to respond to more individual needs and to develop innovative new programs. Programs like hospice care for the terminally ill, a church-sponsored adult foster care home, and a series of residential alternatives to nursing home care have been introduced or are in the planning stages. In addition, the LOVE, Inc. Church Service Network offers one-day seminars for church and agency representatives in other Michigan communities and a series of training topics. Most important, LOVE Inc. continues to educate church members to the elderly's needs and to the role they can play in meeting those needs.

Further information is available from: Dr. Virgil Gulker, President, LOVE Inc. Church Service Network, A4313 Blue Star Highway, Holland, Mich. 49423.

News Notes

Peoples Drug Joins NIA In Information Program For the Elderly

Peoples Drug store chain, headquartered in Alexandria, Virgina and HHS' National Institute on Aging (NIA) are partners in a new program that is providing valuable health and social service information to the elderly.

More than 500 drug stores in the Peoples chain, including Haag, Lane, and Reed-Lee pharmacies, are disseminating free booklets on a variety of subjects of special concern to older people.

The booklets cover such topics as safe use of medicines, high blood pressure, skin care, nutrition, tips on finding good medical care, coping with heat and cold, and accident prevention. Information in the booklets is supplied and checked by physicians and staff of the National Institute on Aging.

Peoples pharmacies, which stretch from Minnesota to Alabama, are also distributing nine regional directories of services available to the elderly in counties served by the drug store chain. The guides list Area Agencies on Aging and include information on where to go and what to ask for in seeking housing, employment, recreation, nutrition, home nursing, and other services focused on older Americans.

The Peoples organization is also supplying their pharmacists with materials on aging from NIA and encouraging them to become involved with local senior citizen organizations to improve health education for the elderly.

"The pharmacist is almost like your local medical professional—not like a doctor of course—but usually closer to the elderly neighborhood residents," a Peoples spokesman commented. "The elderly feel free to ask questions, so pharmacists are in an excellent position to provide day-to-day health education."

Started last October by Dr. Robert N. Butler, former director of NIA, and Sheldon Fantle, president of Peoples Drug, the "Living with Aging" program has been widely praised as a good example of an effective partnership between business and the federal government in providing a public service.

New Prize To Be Awarded For Gerontological Research

The International Association of Gerontology has announced that it will award a new prize, worth $10,000, to be sponsored by SANDOZ LTD, of Basel, Switzerland, for gerontological research.

The purpose of the prize is to encourage research in all areas of gerontology and geriatric medicine, including the biological, medical, psychological and social aspects of aging, with emphasis on multidisciplinary research programs.

The Sandoz Prize for Gerontological Research will be awarded every second year beginning in 1983 by a jury composed of members of the Executive Committee of the International Association of Gerontology.

Applications in English should consist of a summary of 3-5 pages, a curriculum vitae, a bibliography and not more than 5 pivotal publications in English, or extended summaries of these publications in English.

Individuals and research teams or institutions should submit their applications not later than September 30, 1982 to: Prof. M. Bergener, Secretary General, International Association of Gerontology, Rheinische Landesklinik, Wilhelm-Griesinger-St. 23, D-5000 Cologne 91, Germany. Tel. (0221) 899 32 01.

Amtrak Gives Seniors Bigger Discounts

Amtrak is offering senior citizens and handicapped people greater discounts on train fares.

Since 1980, elderly and handicapped people have been able to travel at a 25 percent discount for one-way fares over $40. Now, the 25 percent discount applies to all round trips, and the $40 minimum fare has been eliminated.

To receive the discount, seniors must present a driver's license, birth certificate or other official proof that they are 65 or older.

Amtrak also has special services to assist senior citizens in traveling. These include assistance in boarding and leaving trains as well as special meals and other on-board services for those people who cannot take advantage of regular services. Older people should give advance notice to Amtrak of their need for special assistance.

Prudential Increases Support for Health Screening of Seniors

Health fairs for older Americans, which in 1981 provided health screening to 80,000 senior citizens across the country, are being organized again this year through a joint program of the National Health Screening Council for Volunteer Organizations, Inc., (NHSCVO) and the Prudential Foundation, a philanthropic arm of the Prudential Insurance Company of America.

Prudential has increased its support for health fairs specifically set up for the elderly from $78,000 in 1981 to $148,000 this year. Funds are used to pay for the rental of screening equipment, medical forms, and for training volunteers from local agencies and organizations, such as area agencies on aging, retiree associations and religious groups, to conduct the health fairs.

Other corporations, including Chevron and the Ceiba-Geigy pharmaceutical firm, are providing funds for health education and health fairs for people of all ages, which are also being organized by NHSCVO and local volunteer groups. In 1981, these general health fairs, sponsored by organizations ranging from Kiwanis to professional women's groups, screened 433,000 people, including 60,000 senior citizens.

The fairs offer a minimum of four screenings measures of height and weight, visual acuity, blood pressure and detection of anemia plus a personal health history and health counseling. Communities also may offer free tests for glaucoma, hearing problems, certain types of cancer, and for a modest fee, a blood test for diabetes, liver and kidney function, gout, and cholesterol level.

Volunteer nurses, ophthalmologists, dentists, and other medical personnel perform the more complicated tests, with trained volunteers measuring height and weight, registering the elderly and carrying out other support functions. Each test and its results are explained to participants, with emphasis placed on educating the public on how life styles and habits affect health.

NHSCVO staff member Rebecca Silver says a health fair can take place in any city or town in which community organizations or individuals wish to sponsor the event. Information on how to start planning a health fair is provided on NHSCVO's toll-free nationwide telephone number (800) 638-8087, or in Mayland (301) 657-8480. Training assistance is also available from NHSCVO, along with an "A to Z" manual on how to conduct a health fair.

Mrs. Silver notes that in addition to the volunteers provided by community organizations, local television stations and newspapers announce the fairs, and business firms usually donate printing facilities, lunches for volunteers and other support.

Commenting on the success of the older American health fairs, Dr. John F. Brensike, president and founder of NHSCVO, recently remarked: "In a time of rising costs, inflation, and growing pessimism about how to meet health care needs, the Health Fair Programs demonstrate how the commitment of diverse community organizations, working together, can produce an effective health promotion and disease detection service built on existing resources."

The Older American Health Fair Program was started in 1979 with a grant to NHSCVO from the Administration on Aging, with the Prudential Foundation picking up financial sponsorship of the program in 1981.

For further information, contact: Rebecca Silver or Cynthia Hickman, NHSCVO, 5161 River Rd., Bldg. 2, Bethesda, Md. 20816.

Seniors Wanted To Write Imaginative Folk and Fairy Tales

"Remember the stories you were told when you were a child? The fairy tales? The vignettes, the tales of your people and particular background? Keep them alive and write them down."

That intriguing invitation is the opening of a flier being circulated by a former school teacher and an editor who plan to edit a book of folk and fairy tales written and illustrated by senior citizens.

"This is an opportunity for senior persons to dig into their memories and ethnic backgrounds and create their own tale," says Olga Drucker, author of many articles and stories and current editor of *Elder Leaves*, a senior digest. Her co-editor for the planned new collection of folk tales is Jeannette Fidell, a retired teacher from the New York City school system and published author of children's books.

Each senior person whose story or vignette is accepted will share in the book's royalties. Stories are to be approximately 2-3 pages and should be sent together with a self-addressed, stamped envelope by June 30, 1982 to: Olga Drucker, c/o Elder Leaves, Inc., 65 Nancy Blvd., Merrick, N.Y. 11566.

Prepaid Health System For Brooklyn Elderly In Planning Stage

The Metropolitan Jewish Geriatric Center of Brooklyn, N.Y., has received a foundation grant to design "Elderplan," a prepaid health plan that will offer comprehensive health and social services to the well and impaired elderly—ranging from routine eye exams and dentures to housekeeping services and nursing home care.

The $295,000 grant from the John A. Hartford Foundation of New York City will be used by Metropolitan, a 915-bed long-term care institution, for the first-year development of Elderplan, one of the nation's first Social/Health Maintenance Organizations (S/HMO) for the elderly. The Brooklyn program and two other projects were selected last year by HHS' Health Care Financing Administration to be part of a national demonstration of the new S/HMO concept of caring for the elderly.

S/HMO is a comprehensive social and health care delivery system, financed by Medicare, Medicaid and private premiums, which will provide preventive, medical, hospital, rehabilitation, home health and personal services and extended nursing home care under a predetermined fixed budget.

In 1983, Elderplan will begin enrolling from 4,000 to 5,000 older people living in a section of Brooklyn where approximately one-third of New York City's elderly people live.

According to Dennis L. Kodner, director of the Elderplan project, about 75 percent of the subscribers will be well elderly and 25 percent chronically impaired. Kodner notes that all the subscribers will be enrolled in Medicare and that 25 percent will also be covered by Medicaid.

He says Medicare is likely to contribute about $200 a month—the average monthly amount currently paid out by Medicare per elderly person in Brooklyn—for every person in the Elderplan program who is only covered by Medicare. These subscribers will also pay additional premiums of roughly $40 to $50 a month, bringing the yearly cost of Elderplan for this group to $3,000. It is anticipated that Medicaid will pay upwards of $4,500 a year for each of its Elderplan enrollees.

Kodner explains that because it is an experimental project, Elderplan expects to receive permission to use Medicare dollars to provide services not currently available from the federal health program. Elderplan, for example, will pay for extended nursing home care without requiring a prior stay in a hospital and will finance placement in Intermediate Care Facilities—two practices prohibited by Medicare rules.

Elderplan will also offer a range of services not available under Medicare that are designed to keep the elderly out of nursing homes, including home-delivered meals, medical transportation, housekeeping services, and adult day care. In addition, preventive health services not covered by Medicare will be offered, such as hearing and eye exams, coverage of prescription drugs and routine podiatry. Federal approval of flexible use of Medicare and Medicaid dollars in the demonstration is anticipated soon.

Most of the social and health services will be provided through a single site—the Metropolitan Jewish Geriatirc Center—with physician services provided by Cornell Medical College's Division of Geriatrics and Gerontology and hospital care by Caledonian Hospital and Cornell's New York Hospital.

Kodner says emphasis will be placed on case management, planning with the elderly person and his or her family to insure that "no less or no more is provided than needed," with the goal that "the least restrictive environment for the elderly is best."

According to the project director, the S/HMO concept "is designed to correct the problems of lack of access to services, provision of inappropriate services and high costs which characterize the present health system for the older population."

Working within a prospective fixed budget, Kodner says Elderplan "will insure that dollars don't fly out the window. The elderly in Brooklyn will not have to navigate a complex and fragmented medical system. They will have no forms to fill out or other bureaucratic hassles and will receive a full range of services provided by a group of physicians committed to geriatric care."

If the model is successful, Kodner believes it will encourage other geriatric centers, existing HMO's and hospitals to provide comprehensive services to the elderly.

During its planning and development phase, Elderplan will receive technical assistance from the University Health Policy Consortium at Brandeis University, which received a grant from the Health Care Financing Administration to develop the S/HMO concept and supervise the national demonstration. The two other sites in the demonstration are the Ebenezer Society of Minneapolis, a long-term care facility, and the Kaiser-Portland HMO in Portland, Ore.

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Submitting Articles

AGING Magazine welcomes news and information from its readers. Especially valuable are stories about innovative programs or projects which have worked well and can be duplicated or adapted for use elsewhere. Material should be typed and should not exceed 15 pages double-spaced. Articles may be bylined. In all cases the Editor reserves the right to make changes in length or style or presentation.

Photos, if any, should be captioned. Black and white, 5" by 7" or larger glossy photos are preferred. Color snapshots are not acceptable. Photos cannot be returned unless accompanied by a self-addressed envelope or mailing label.

Information for Conference Calendar and Course Calendar should be submitted at least 12 weeks prior to the issue month in which they are to appear.

All material should be sent to Editor, AGING Magazine, Administration on Aging, Room 4245, 330 Independence Avenue, S.W., Washington, D.C. 20201.

Information

Information about articles appearing in or submitted to AGING Magazine may be obtained by writing the Editor at the above address or by calling (202) 245-1190.

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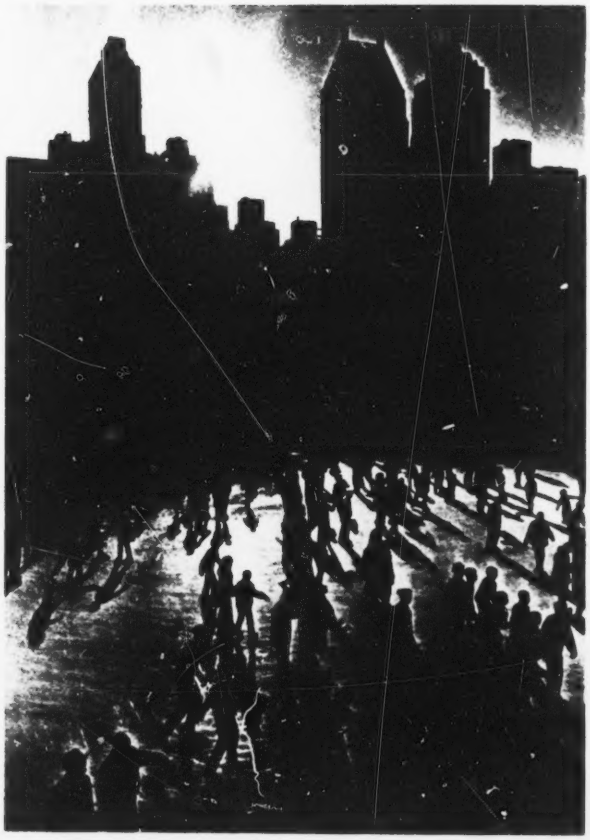
Use of funds for printing this publication approved by the Director of the Bureau of the Budget, November 31, 1978.

DISCRIMINATION PROHIBITED—Title VI of the Civil Rights Act of 1964 states: "No person in the United States shall on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Therefore, the programs discussed in this publication, like every program or activity receiving financial assistance from the Department of Health and Human Services, must be operated in compliance with this law.

ORIGINAL [illegible]

Aging

November-December 1982
Nos. 333-334



ON THE COVER

Cover photo "Central Park South" by Gary Franklin was shown at the retirement center art gallery, which has featured many outstanding artists and photographers. (Story on page 12)

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Aging

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Richard Schweiker **Secretary of Health and Human Services**
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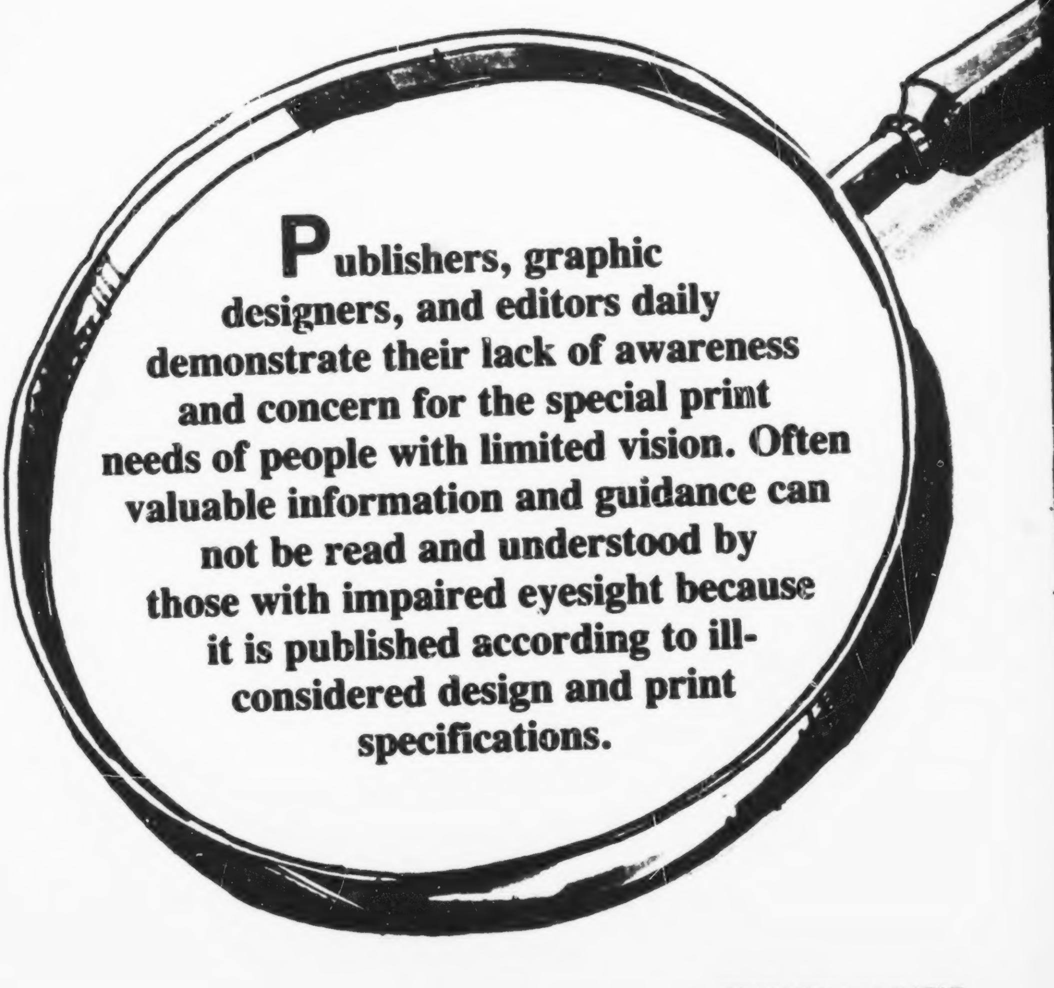
Visual

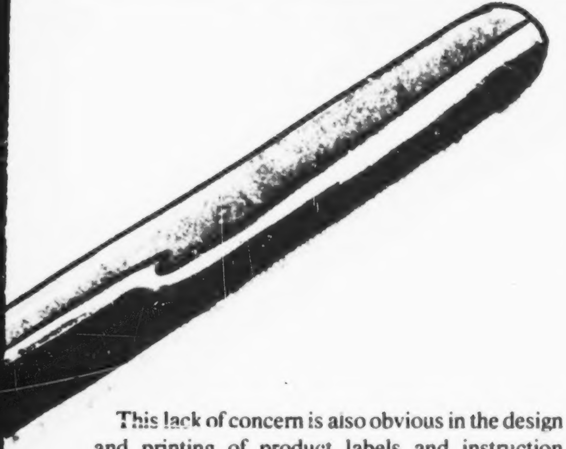
Visual Booby Traps for Our Aging Population

Jack B. Ralph*



Publishers, graphic designers, and editors daily demonstrate their lack of awareness and concern for the special print needs of people with limited vision. Often valuable information and guidance can not be read and understood by those with impaired eyesight because it is published according to ill-considered design and print specifications.

"If the average person must squint to read these warnings . . . imagine the difficulties of the visually impaired."



This lack of concern is also obvious in the design and printing of product labels and instruction manuals for appliances and equipment — a situation which increases the danger of accidents in the home.

The group most seriously affected by present design and printing practices are the aged because they have a high incidence of visual problems. With little apparent awareness of the impact of these practices, the publishing and graphics industries are compounding the problems of those suffering loss of visual perception and are contributing to the creation of a special class of handicapped persons.

What good is a written warning if you can't find it, see it, or understand it? The safety of millions of people is jeopardized everyday because they cannot see, read, or understand the cautions on the labels of consumer products. The print on the labels is too small. The color of ink or paper reduces visibility. The vocabulary is too technical, specialized, or is not dramatic enough to serve as an adequate warning.

The most visible printing combination is black ink letters on white paper. Any print lighter than black or paper darker than white decreases the contrast. As individuals age, the need for contrast increases because of discoloration in the eye fluids and lens. Such combinations as brown print on tan, or blue ink on pink paper are ill-advised for sight-impaired elderly people. In addition, dark red ink printed on pink paper appears as gray on gray to certain people with degrees of colorblindness.

But contrast is not the only problem. The size of the print is very important. To give the reader a brief initiation into the world of printing, the following common type sizes are presented along with their technical point designations:

This is fourteen (14) point type.

This is twelve (12) point type.

This is eleven (11) point type.

This is eight (8) point type.

This is six (6) point type.

The size of type legally required to warn consumers that a product or medication may be fatal or injurious if improperly used is too small for most people to read easily. In fact, the legally required size print for medication warnings is smaller than the size of print in telephone directories. Help wanted ads generally appear in 6-point type, hampering job hunting efforts by the elderly. Newspapers are often printed in 8- or 9-point type, and many pamphlets and brochures on community services use typewriter type, usually a 10-point size.

The minimum recommended size type for the general population, however, is 11 points. Twelve point size type (about 1/6-inch high) is suggested for the elderly, and 14 points is the minimum

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***Mr. Ralph is an Equal Opportunity Specialist in the Office for Civil Rights, Department of Health and Human Services. He has received an Exceptional Achievement Award for his work in the development and use of design guidelines in the production of information documents for use by the aging, visually limited, and general public.**

"Reading problems related to abnormal vision occur from childhood to adulthood . . .

approved for the severely visually handicapped.

Unfortunately, the use of these recommended type sizes is often ignored by government agencies, businesses, and manufacturers. For example, room air fresheners are packed in aerosol cans which must display warnings that puncturing or exposure to 120° heat can cause explosions. This warning on one particular scent of aerosol freshener is displayed in print that is below the 11-point size recommended for the general population. What is worse, however, is that the can has a white background with the hazard warning printed in a chrome reflective paint, offering no visual contrast. Neither the marketing and graphics specialists nor the engineers and technicians of this company seem to have been able to suggest that the design of these labels should effectively warn people with poor eyesight about the explosive hazards of aerosol sprays.

The Number of Visually Handicapped

It is difficult to provide accurate statistics on the number of visually handicapped people in the United States. Reporting of visual impairments is complicated because persons with multiple vision problems can be counted more than once. Consequently, the following category totals should not be added together to make a grand total of people with limited vision. The totals in any one of the categories, however, would seem to justify the need for addressing the problems created by the use of small type size in printed warnings:

- 500,000 persons are seriously visually limited, and need a mechanical apparatus to read even "regular" or 10-point size print.
- 1 million persons are severely visually impaired and cannot read ordinary 8- or 9-point size newsprint with glasses.
- An additional 10.5 million persons cannot read small size 6- to 8-point print and printed materials in certain colors and combinations of ink and paper.
- An estimated 20 million people wear glasses and contact lenses with prescriptions no longer suited to their vision needs.
- It is estimated that another 20 million people have need of some visual correction but do not know it.

Reading problems related to abnormal vision occur from childhood to adulthood, but they are frequently compounded in later years by the degenerative visual problems that accompany aging. The reduction or loss of vision with age, including the decline in near vision, is caused by increased yellowing of the lens with age, retinal disorders, corneal or scleral problems, increasing clouding of the vitreous (eye fluid), and other conditions.

Since it is projected that the proportion of elderly people in the population will rise dramatically over the next several decades, a higher incidence of visual problems should also be anticipated. For a significant number of elderly people who lack adequate financial resources or insurance coverage, these problems are likely to go uncorrected. With eyes unable or ill-equipped to deal with small print, an increasing number of elderly will be excluded from normal visual communication, become more subject to accidents, and be more susceptible to legal entanglements and misunderstandings when signing documents.

While print size will be the largest obstacle for many older people, others will suffer from physiological problems which reduce the amount of light transmitted to the retina, causing an inability to read anything on colored paper. Clouding of the lens (cataracts) also reduces color and contrast recognition. To see color contrast as a cataract-impaired person sees it, put several sheets of amber colored plastic over printed material. The amber may make some colors brighter, but more often reduces perception.

Publishers, advertisers and product manufacturers who do not think about use of color in ink and paper should be made aware that:

- 8.5 million men and 650,000 women in the U.S. are color deficient ("colorblind").
- Thousands of people are color deficient on a temporary basis because of a changing physiological condition.

. . . But they are frequently compounded in later years by the degenerative visual problems that accompany aging."

- Colorblindness often goes undiscovered because the tests to detect this handicap are administered when environmental factors are not correct.

Although this discussion is chiefly concerned with the reading difficulties of the visually impaired, the problems posed by technical vocabulary on instruction and warning labels to people with limited reading and comprehension skills should not be ignored. The extent of reading deficiencies in the general population is reflected in the following statistics:

- The average grade reading level is very low for 14 million citizens who are deaf or hard of hearing.
- About 25 million persons are functionally illiterate (reading at the fifth grade level or less).
- Approximately 37 percent of the adult population, or 45 million persons, read below the eighth grade level.

With so many people unable to read or understand very well, it does not seem satisfactory to allow the listing of the chemical contents and formula of a hazardous product to serve as its only warning. There are many consumers who do not know or understand the ionizing effect of chlorine or the risks of mixing cleaners which, when combined, can release extreme heat and toxic and explosive gases. Not everyone can use the jargon, buzz words, and key terms of chemistry and medicine. The use of words on a label such as caustic soda, lye, corrosive reaction, irritant, hazardous, and volatile make a warning meaningless to many users. Words, such as vertigo, on labels for prescribed or over-the-counter drugs, are also incomprehensible to many people.

Warnings Invisible

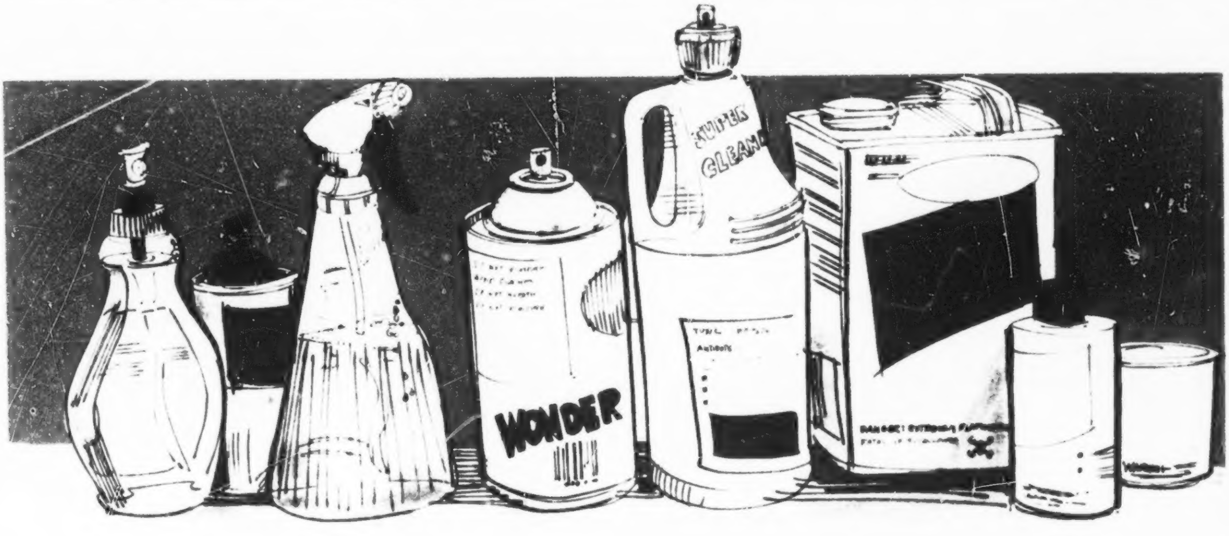
For the visually impaired, warnings on prescription drug bottles are printed in such small size type and in such low-contrast ink to paper color combinations that the warnings are effectively invisible to millions of people. In general, the printed cautions about drowsiness sometimes induced by antihistamines and other compounds, the dangers of combining certain medications with alcohol, and the suggested restrictions on driving are visually unacceptable.

Seemingly harmless substances can also present a danger to people with poor eyesight or color blindness. The hazards of using my wife's bath oil beads for "dry skin relief" were dramatically demonstrated to me recently when I slipped getting into a half-full bathtub that contained the miracle beads. While sitting in the tub, recovering from the shoulder strain I sustained in breaking my fall, I examined the clear plastic bottle that contained the solution. The label on the front of the bottle gave the name of the product and its manufacturer in large, beautiful print. On the reverse side of the bottle, through the dark blue solution, I was barely

"Seemingly harmless substances can also present a danger to people with poor eyesight or color blindness"

BEST [illegible]

"What good is a written warning if you can't find it see it, or understand it?"



able to read the caution, printed in 10-point light blue ink, advising me to "guard against slipping in the tub and shower." A cataract sufferer would have had great difficulty reading the light blue printed warning through the dark blue solution. A color deficient person would see very little, indeed.

Try taking a short tour of your own household. Does your oil-based paint and paint thinner carry a clearly visible, large type, properly contrasted, prominently placed warning, stating that proper ventilation should be provided in the room where the do-it-yourselfers are doing it themselves?

Is the "keep away from flame" warning on fingernail hardener visible enough for women to read to remind them not to smoke while they "do" their nails? Is the warning on the back of a color television set large and visible enough to warn you against taking the back off and exposing yourself to about 25,000 volts of static electricity buildup on the picture tube?

If the average person must squint to read these warnings or hold them up to bright light, imagine the difficulties of the visually impaired.

There is, however, a body of information on printing and graphic design available to publishers and manufacturers which addresses the needs of people suffering from a loss of visual perception and recommends necessary adjustments. These adjustments deal with type size, type style, leading, the color of ink and paper, contrast, paragraphing, hyphenation, margins, capitalization, paper finish, and other specifications.

The author has published guidelines describing these adjustments, and has enlisted the support of experts in vision, aging, and languages to form a non-profit organization, Better Communications, Inc. The purpose of the organization is to research and promote better visual communications for the visually impaired, blind, deaf, and those with poor reading skills.

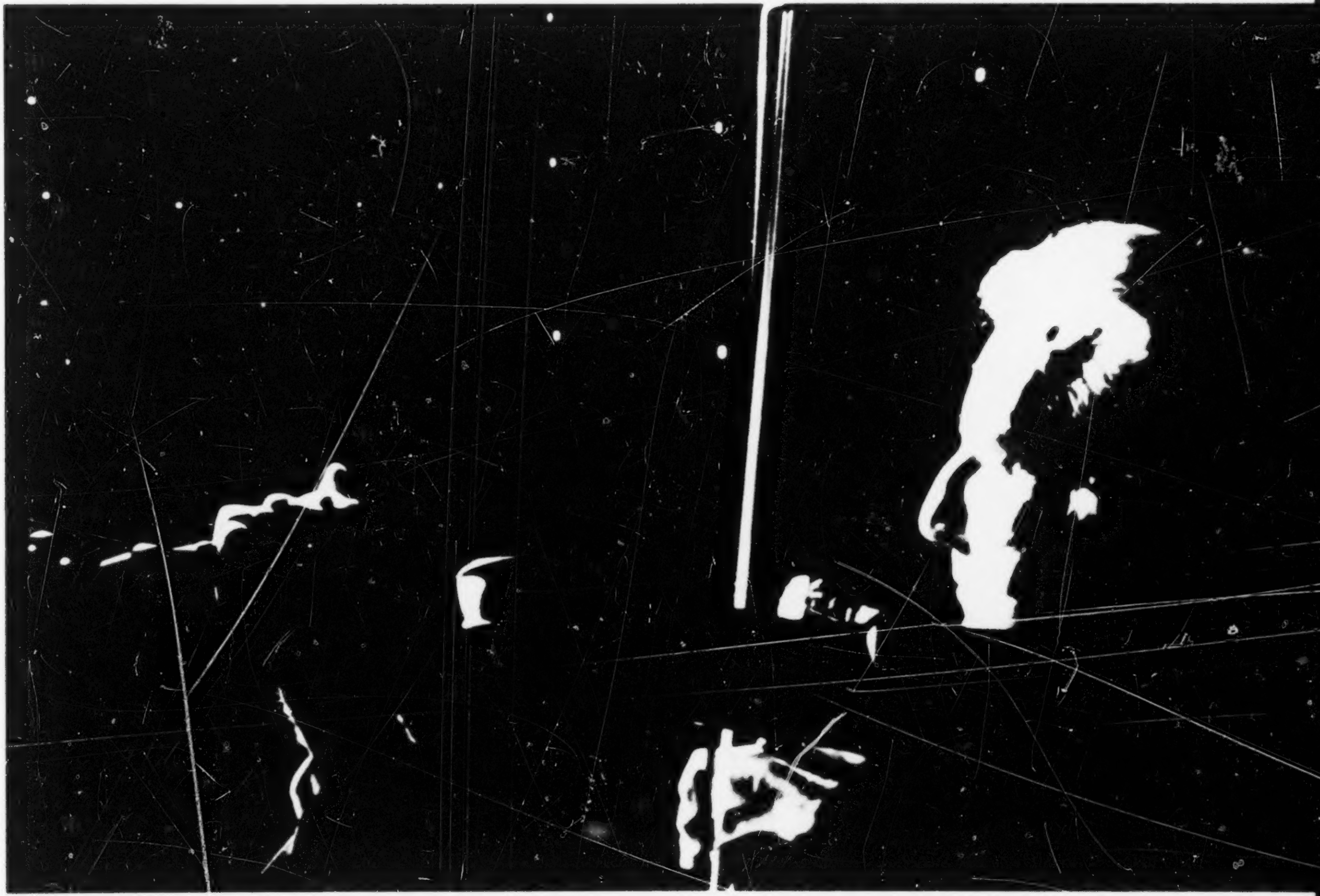
If minimum guidelines are followed in printing and graphic design, visual communication will be made more accessible to sight-impaired people, young and old, booby traps created by printing design will be eliminated, and printed communication for the general reading public will be greatly improved.

For further information, please contact: Jack B. Ralph, Box 1833, Silver Spring, Md. 20902. Telephone: (202) 245-7196.

Music

Reaching the Confused and Withdrawn Through Music

Laura Paulman



"Different music stirred different people, and it was up to me to remember what music belonged to whom."

As a professional musician who teaches piano and organ, I became interested in using my musical ability in work with the elderly. Several years ago, I enrolled in the gerontology program at Kean College, in Union, New Jersey, where one of my courses required an internship in a nursing home. I chose Workmen's Circle Home in Elizabeth, New Jersey, where I developed a music therapy program for residents who were confused and disoriented.

The effects were very positive — residents who usually just stared or slept smiled, while other people tapped fingers or moved a foot. They sang, listened, and even asked for special songs. The music, as it does for many people, stirred memories both happy and sad. An elderly man cried during the playing of "Anniversary Waltz," because it reminded him of dancing with his wife years before. One woman who never spoke, started to sing, knew the words to many of the songs, and amazed the staff who, up until that time, did not think she had any capabilities at all.

The internship lasted 16 weeks, and both residents and staff looked forward to the weekly program which became a source of motivation for everyone. When the staff saw that someone was capable of more than sitting, staring, or sleeping, no matter how small the capability, they attempted to do more with that person, thus giving the resident some self-esteem. The residents knew that they had accomplished something and smiled when the staff applauded and continued to encourage them. The program also had a positive effect on the residents' families who were pleased when they saw their parents had accomplished something or were more in touch with reality. After all, the families constantly tell the staff: "You should have known my parent when she (he) was younger. My mother (or father), was the life of the party . . ."

By chance, the Kean College public relations department wrote an article about my internship for a local newspaper, and I was fortunate to have the article read by Philip Pearlman of the New Jersey Division on Aging who, in turn, contacted me about a grant for music therapy at nursing homes. My immediate response was, "Yes, I'll do it. When?"

The $4,000 grant that I received for the project was supported with funds from Title III-B of the Older Americans Act. The program was designed to provide 1 hour per week of music therapy for 6 months to approximately 75 confused and disoriented residents in each of five nursing homes in Union County.

Music therapy is the controlled use of music in the treatment, rehabilitation, instruction, and training of persons suffering from physical, mental and emotional disorders. Music, sometimes even more than the spoken word, lends itself as a therapy because it meets with little or no intellectual resistance and does not need to appeal to reason or sound judgment in order to initiate action. The program set out to test the hypothesis that music therapy will help withdrawn patients in nursing homes to regain a sense of reality and will add to the quality of their lives.

Responses to music may take the form of a noticeable change in expression or facial color, or in physical responses to the rhythm. A person may respond deeply to music, however, without presenting any overt indication of his or her reaction. Also reactions to musical stimuli may be immediate and direct or they may be delayed and indirect.

Alert Residents Help the Withdrawn

Calls to nursing homes informing them that a music program could be provided 1 day a week for 26 weeks at no cost were met with enthusiasm. Two of the homes initially contacted disqualified themselves — one because it did not have a piano (the musical instrument I had selected for the project) and another because they already had a music program. The activity director said she didn't want to be greedy and deprive another nursing home of such a worthwhile project. In fact, the director said that if the residents at her home could have only one activity, it would be music; because music appeared to go the farthest distance in reaching and stimulating the most people. Eventually, five homes were selected, and when the project was completed, two of these homes hired me to continue a music program.

For the project, I asked each nursing home to select a permanent group of 10 to 15 withdrawn residents to be seated every week in a semi-circle next to a piano, away from other activities and other people. The last request was not possible. Nursing homes, as a rule, do not have specially equipped music therapy rooms. The best setting that I could arrange was to have the residents grouped around a piano, sometimes away from the other people. There were no closed doors.

In one nursing home, a heavy upright piano faced a wall, and I constantly had to twist and turn while playing in order to gain and keep the residents' attention. Another had a partially drawn curtain that separated the music area from a large recreation room. However, after the program began, the people did not want the curtain closed. Even if some residents did not come into the music room, they wanted to hear the music and watch the activity. Because of this, residents who had not been chosen for the program and who enjoyed music and wanted to sing, could hear us and would either come into the area, or make it known to the staff that they wanted to be taken to "music." Sometimes, residents would not even appear to have any involvement in the program but would call or nod to me when I was leaving, ask for a special request, or just thank me for giving them pleasure.

Since none of the nursing homes could provide a private room, I had a distraction variable in every home. Actually it was a "people had access to us" variable and this provided some positive results. It was usually a more alert resident who either wheeled into our area or asked for someone to wheel her to us. This enthusiasm added to the group. He or she usually started singing first, talked more, and the withdrawn were then motivated to join in. However, I did not permit an alert person to monopolize the program. Interestingly, there was no resentment from the alert people toward the confused. They would talk and sing to the withdrawn residents, hold and swing their hands in rhythm, or try to encourage them to sing, talk or smile. The more alert residents felt needed and useful, and the withdrawn person was encouraged to participate by a peer.

The constant requests of other residents to join appeared to prove that the sound of music and singing draws people together and that they will then socialize naturally or with a little encouragement. At the end of a program, I shook hands with each resident and said goodbye by name. The touch was important, and they looked forward to the next time that we would meet.

The ideal situation for evaluating the program, of course, would have been to have the same people every week. But that was impossible — even with the primary group of the more confused and withdrawn residents. I had no control over visitors or illnesses, and, sadly, some of our participants died.

When a person died, it was important for the others to be able to talk about the loss. We would say something about the person and have a moment of silence. The residents also seemed to feel that singing that person's special song was like a memorial to him or her. People in nursing homes, as a rule, think that they will not be remembered by the other residents after they die. As the facilitator, I also had to deal with "death." It was some comfort to me to know that through music, we had made the person's days happier and more meaningful.

Keys to Success

In the beginning of the program at each nursing home, after introductions, I provided some orientation on the program's objectives and how it would proceed and answered any questions from the group members. Residents also were always told by the staff that they were going to music. People sometimes appear withdrawn and disoriented because no one is giving them any information or explanations. For this reason, orientation continued to be an important part of the music program.

I never delayed in starting the program and kept it moving, because a facilitator risks losing an audience if a program slows down. If I started a new musical game or movement and it did not seem to be reaching enough people at that particular time, I restructured it immediately to something familiar so that they would feel comfortable again. The participants tell you what they like and how they feel. The facilitator, or anyone taking care of them, must watch carefully. The fact that a person appears withdrawn and seems not to be listening does not mean that this is so. Withdrawn and seemingly confused people do hear us and have feelings. Later in the program, I might return to the original game or movement. Once it was more familiar, it could become a regular part of the program.

When a member of the group is especially moved or aroused by the music, special attention must be given at that particular moment. (Sometimes, a confused person's sudden grasp of reality passes quickly and you cannot return to that moment in the same manner again.) It was also important for me to hold the group's attention while I was focusing on a particular individual. Everyone had to become a part of that special moment.

Each program began and ended with the singing of "God Bless America." Most residents knew the song and it put smiles on their faces, sometimes tears in their eyes, and fervor in their voices. Also "God Bless America" signaled the beginning of the program for the staff, so they could bring more residents to participate. By singing it again at the end of the hour, the staff knew it was time to come over and take care of the residents. This provided continuity for the program and gave the residents security. They do not like to sit in their wheelchairs after an activity and wonder what comes next. The singing was always stronger at the end of a session. Some staff joined us at different times during the sessions by singing, dancing, or holding a resident's hand in order to stimulate movement or a smile.

It appeared that confused and disoriented residents benefited the most from strong rhythmic music because it elicited motor responses such as clapping, tapping the feet, walking, and nodding the head. This type of music also appeared to stimulate appetites before meals and to create an overall feeling of well-being. Rhythm instruments were used to induce active participation, and the confused residents were assisted in playing them. Waltzes, folk songs, marches, and lively familiar songs produced excellent results.

In the beginning, I structured the program but as I became acquainted with the residents and their preferences, orientation and ethnic backgrounds, I helped them to design part of the program and to take some control. This was very important, because one of the biggest problems in nursing homes is the residents' lack of choice and loss of control over their lives and activities.

I always introduced myself as "Laura" and constantly spoke to each resident by name in order to build confidence and rapport. Calling residents by their names reinforced self-esteem and the feeling in the group that each person had a unique identity. (For some residents, their name is virtually all they can respond to, and hearing it repeatedly is very important.)

The first day in all the nursing homes was spent playing music almost continuously and watching carefully for overt responses to the various tempos and tunes.

Residents preferred songs with a fixed

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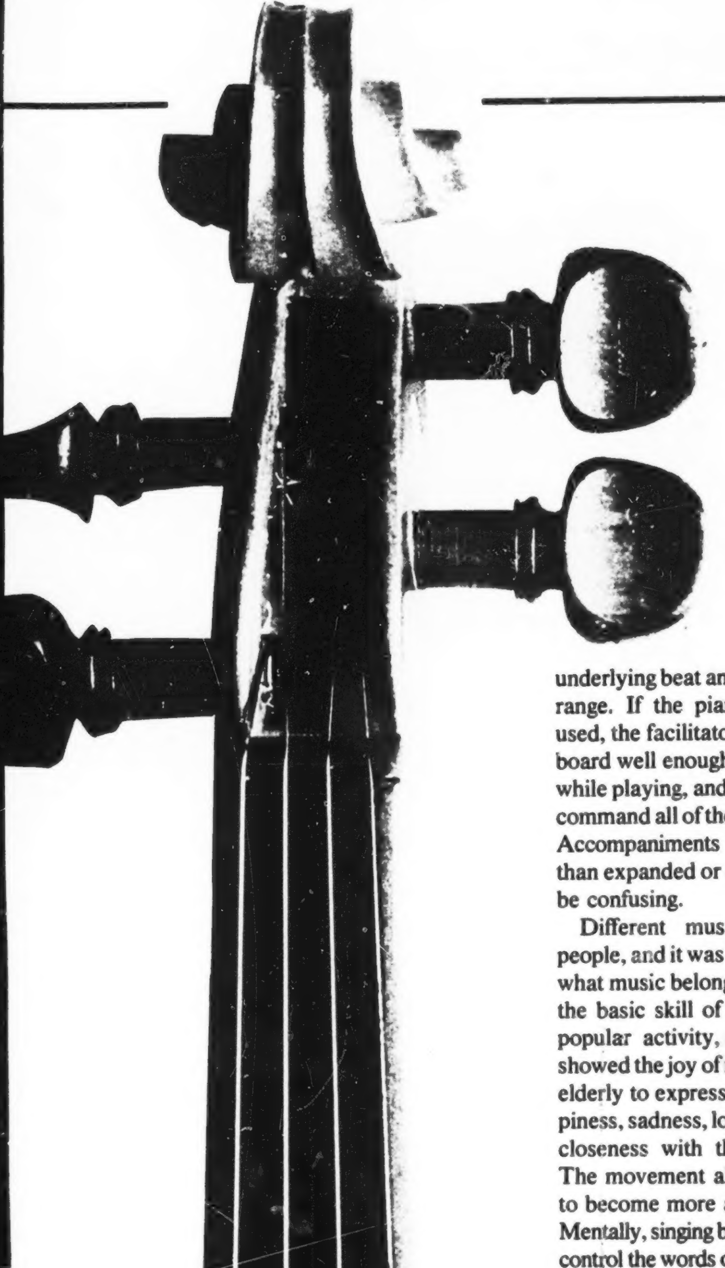


"The challenge for the therapist is to become sensitive to the "singing" in a smile, a movement of the body, a tap of the finger or glimmer of the eye"

underlying beat and a comfortable vocal range. If the piano is the instrument used, the facilitator must know the keyboard well enough to look away from it while playing, and sheet music must not command all of the therapist's attention. Accompaniments were simplified rather than expanded or decorated so as not to be confusing.

Different music spurred different people, and it was up to me to remember what music belonged to whom. Singing, the basic skill of music, was the most popular activity, but body movement showed the joy of music and allowed the elderly to express their feelings — happiness, sadness, loneliness, or feelings of closeness with their fellow residents. The movement also helped the elderly to become more aware of their bodies. Mentally, singing brought under conscious control the words of the song, the melody, and the person's emotions. Asking the residents to take a breath at the end of a phrase while singing also helped them, because breathing exercised the respiratory system. Paying attention to dynamics, (loud and soft) also required some control.

Tempos were changed for interest. Slower music was used for calming purposes. Music that matched, to some extent, the mood of the resident was found to be advantageous in eliciting responses from depressed residents. For example, they tended to respond more to an andante, or moderate, tempo. It seemed to relieve their depression, and the residents who would not talk would frequently sing with the group. The sessions were structured for reality orientation, reminiscing, exercise (ball toss; naming parts of body; right and left), and learning. Through requests, the participants gained some control of the program, definitely an important goal in nursing homes.

Attention to the specific physical problems of the residents was also crucial to the program. Those with a marked hearing deficiency were placed next to the piano in order for them to feel the vibrations. Those with acute sensitivity to noise were seated at the back of the group.

While singing was an end in itself, it was also used to assist in general social interaction and conversation. After a song was sung, I would ask: "Can you recall when you first heard this tune? What were you doing? Who were you with?" The songs used definitely manipulated the atmosphere. A polka set feet tapping and this became an exercise that strengthened muscles. A well-known song which residents hummed or sang became another way of improving breathing.

I watched carefully to see if the response of an ill or withdrawn resident to different music was a smile or a frown. I then made a mental note of the songs they had appeared to like. From there, I tried to build rapport with the individual, referring to the tunes as Mrs. ________'s favorites, and encouraged the other residents to comment on them, thereby achieving some group relationship to the individual.

"Songs" of the Aged Often Blocked

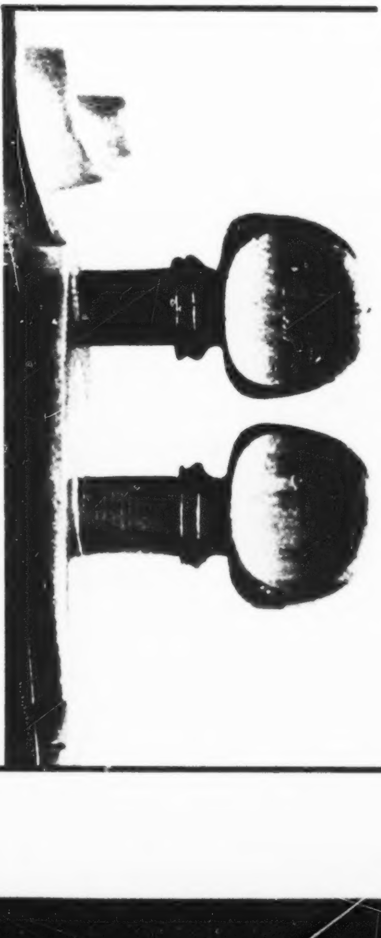
The 26 weeks flew, and then I asked myself: "What had been accomplished? What had happened? Does music therapy work?"

I knew that I had made many people "happy." One alert gentleman wrote words to familiar melodies. I have some "thank you" notes from residents. One resident told me that he was not a religious man and did not believe in God, but then added, "You give me life through the music." This man has since died, but I can still see the light in his eyes which expressed the happiness the music gave to him while he lived. Another woman, who no one realized could speak, is not only singing now, but sings "solo" at special programs for other residents.

I believe that music or a song exists in all of us. The aged who are confused, disoriented, or in some manner mentally impaired, have different ways of "singing." The usual ways of communicating may be blocked, interfered with, or misrepresented. Their "songs" may be rich in meaning but are often difficult to hear or understand. The challenge for the therapist is to become sensitive to the "singing" in a smile, a movement of the body, a tap of the finger, or glimmer of the eye. Then, music therapy works.

Is music preventative medicine? Surely, participation in an activity cannot prevent the occurrence of a stroke. However, a strong interest in some activity can prevent the elderly from adopting and accepting the "withdrawn role." Disuse of the extremities and unawareness of the parts of the body is less likely to occur, because music helps to maintain alertness and spontaneous body movements. Music also promotes social interaction and removes barriers (real or imagined) which so often divide one person from another. Music can improve the motivation of a nursing home resident to regain an interest in life and an awareness of his surroundings.

Music arouses people who are otherwise inaccessible. It can calm, reorient, and motivate the confused and disoriented, even if only temporarily. The meanings of words appeal primarily to the cerebral hemisphere of the brain, but in responding to music, various other parts of the brain can become involved. Thoughts as well as emotions are triggered. According to Dr. Robert Katzman of the Albert Einstein School of Medicine, the portions of the brain that respond to music are the last to deteriorate in illnesses affecting the brain. Consequently, music and singing are suggested treatments to help Alzheimer's disease. People with Alzheimer's disease respond to music, particularly familiar old songs, and can be taught to sing information to familiar melodies. Thus, learning may take place.



I found that music therapy tended to mean different things to different members of the staff. The nursing staff who are worried about the apathy and withdrawal of a resident view music as a socializing factor. A speech therapist will use music as an aid to articulation. Social workers may see music as a stimulus to the talking over of problems and a help in socializing the solitary residents. The occupational therapist may use music to stimulate exercise. The psychologist can use music as a "trigger" to the memory.

Music is effective therapeutically because it is the most social of all the arts, and it is precisely the social aspects of life that are the most affected by mental illness and old age. Through the use of familiar music, an unfamiliar or seemingly hostile environment can be made to feel safe and secure, with the result that conversation and interaction are less threatening and more easily initiated.

Music is already used in the treatment of depression. By diverting attention from the thoughts which generate depression, music provides an effective inroad into the consciousness of the individual and helps him out of his depression. Music can replace a sad and withdrawn feeling with one of pleasure; it can also relieve the inner tensions and conflicts that bring on depression. The rhythmic stimuli of music prompts body movement and activity, which in turn, assists in easing the individual's depression and often draws his attention to an awareness of his surroundings.

The music programs in the five nursing homes were as rewarding to me as they were to the residents. When I walk into a nursing home, I am not as upset as I used to be to see residents sitting in a row, looking bored, sad, or possibly dozing. I know that music can help them to regain a sense of reality and add to the quality of their lives; make them smile, sing, tap fingers, move feet, dance, have feelings, remember, think, and learn. In short music can motivate people to become "alive."

Arts

Fine Arts Gallery In Retirement Center Nurtures Creativity

Priscilla Jones*

"A water color painter capable of interpreting nature on a monumental scale."

"An artist influenced by the specter of the coastal fogs patrolling the coastline, with sunlight passing through their roaming mists . . ."

"The cowboy artist who paints the Navajos and mustangs of his youth . . . his works like visual flashbacks in time."

These are art critics' descriptions of several of the major artists who have exhibited in the nation's first art gallery in a retirement complex, a gallery that challenges the elderly not to ignore the role of beauty in their lives.

Since the Senior Eye Gallery opened in 1974 in the Palmcrest long-term care complex in Long Beach, California, the gallery has had 46 shows of works by major artists, including some of California's best — Max Finkelstein, Nick Brigante and Claire Falkenstein. The Palmcrest complex includes a retirement home for 180 residents, two convalescent hospitals with a combined 198-bed capacity, and an adult day care center.

Dr. Julian Feingold, modern art collector, member of the Palmcrest board of directors, and a prime mover in the establishment of the gallery, believes that learning and creativity must be the central objective for the retired person. He insists that "where there is growth there is life, and where there is creativity

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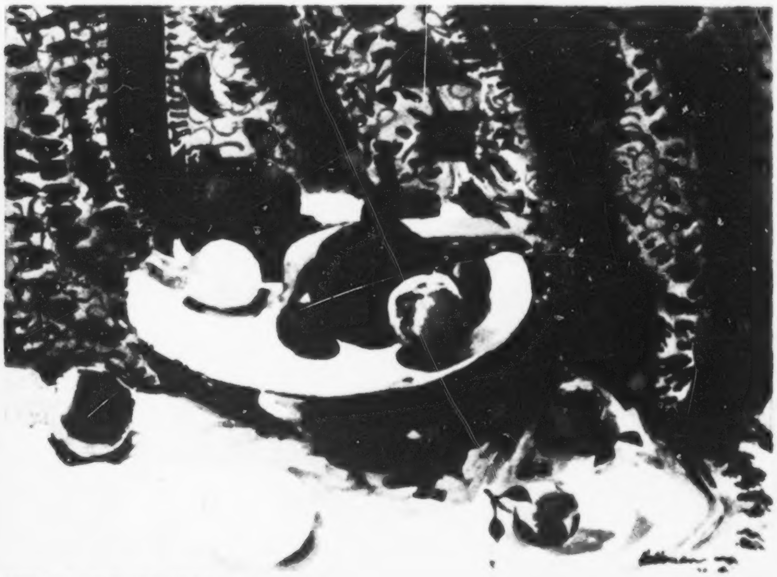
Ms. Jones is Assistant Editor of Aging magazine. She was formerly a member of the Public Information staff of the Administration for Children, Youth and Families.

"Where there is growth there is life, and where there is creativity there is enthusiasm and involvement"



Still life by Robert L. Holdeman

there is enthusiasm and involvement."

Not only have 45 outstanding contemporary artists shown in the Senior Eye Gallery, but 35 of them have contributed works to a permanent modern art collection which is featured in the hallways of all Palmcrest buildings.

Instead of the prosaic wallpaper adorned with uninspiring prints seen in many nursing homes, residents of Palmcrest are greeted every day with broad splashes of color and exciting configurations of line, texture and design.

In addition to awakening the senses and prompting thoughts about life, timelessness and beauty, the art work stimulates the creativity of the residents who each year put on their own gallery show — a popular exhibit called "Art 70 Plus." Palmcrest House has a resident artist on the staff who offers classes throughout the day in painting, ceramics, acrylics, knitting, leatherwork, and photography.

"Nursing home residents have health and recreation needs, psycho-social needs, and at the same time, aesthetic needs," asserts Dr. Feingold. He points out that the Senior Eye Gallery also serves to bring nursing home residents in contact with people living in surrounding towns. "People pour in from the community to see the exhibits which rotate every two months." "There are many, many studies," he adds, "showing that one of the most serious problems of institutionalization is isolation from the community."

Explaining how the exhibits proceed, Dr. Feingold says that each artist comes to show slides and give an informal talk to the elderly in the retirement home and the convalescent hospitals.

"Then, at the dinner we hold for every

Water color by Julie Lavee

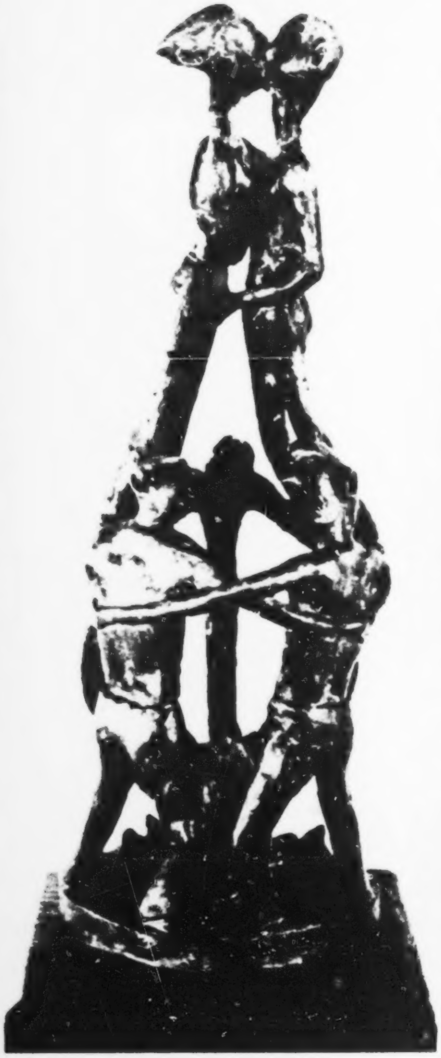
artist, we have 40 people from the Palmcrest residences join the others who attend. We feel that the Palmcrest residents are the hosts of the community."

Over the two-month period of exhibit, small groups of six to eight residents are taken to the gallery to discuss their views on what the paintings, sculptures or photographs communicate. "What does it look like to you?" and "How do you react?" are the typical questions asked. They elicit responses to the contemporary art ranging from the negative and the puzzled to the very positive.

"We have stressed modern art and admit this comes from our bias, since my wife and I are modern art collectors," comments Dr. Feingold. "In the beginning, we wondered what will the reactions of the elderly be to abstract art?" He claims the "broad swatches of color reawaken their senses and spirit and capture their imaginations."

The artists, too, are enthusiastic about the gallery which is booked solid through the middle of 1985. Dr. Feingold says the artists donate to the permanent collection partly because their contact with the elderly residents "makes them want to give something."

Palmcrest takes no commission on sales of the artists works — which so far have totalled $90,000 — and mails out a catalog on each exhibit to 3,000 art lovers. The cost of operating the gallery each year is about $40,000 and is a



"The Kiss" by Louis Monza

"There are many, many studies showing that one of the most serious problems of institutionalization is isolation from the community."

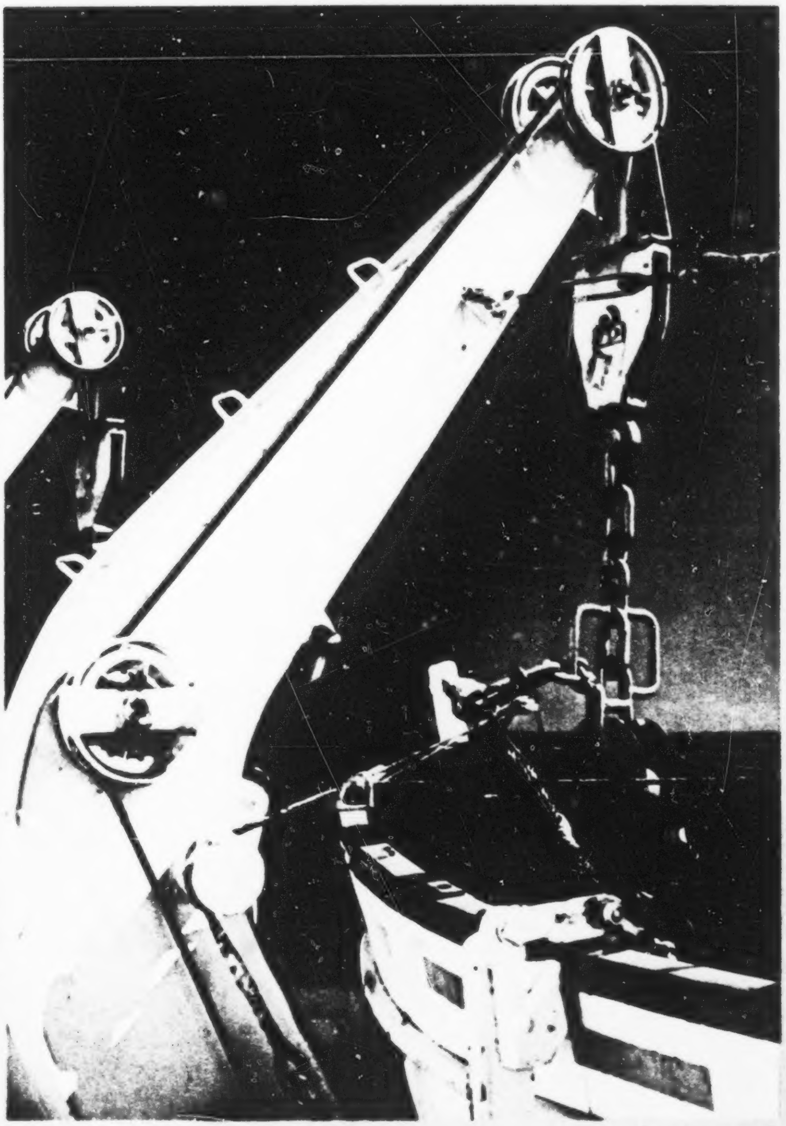


Photo by Si Slavin

permanent part of Palmcrest's budget.

Budgeting art and creativity as a permanent ingredient of the environment of a retirement center? "Most nursing homes think you're nuts if you do this," comments Dr. Feingold. "At the most, they might have a permanent fund for redecorating the walls."

"But this is a place where the elderly may spend many, many months or years — and they need aesthetic beauty," he reiterates. Dr. Feingold also notes

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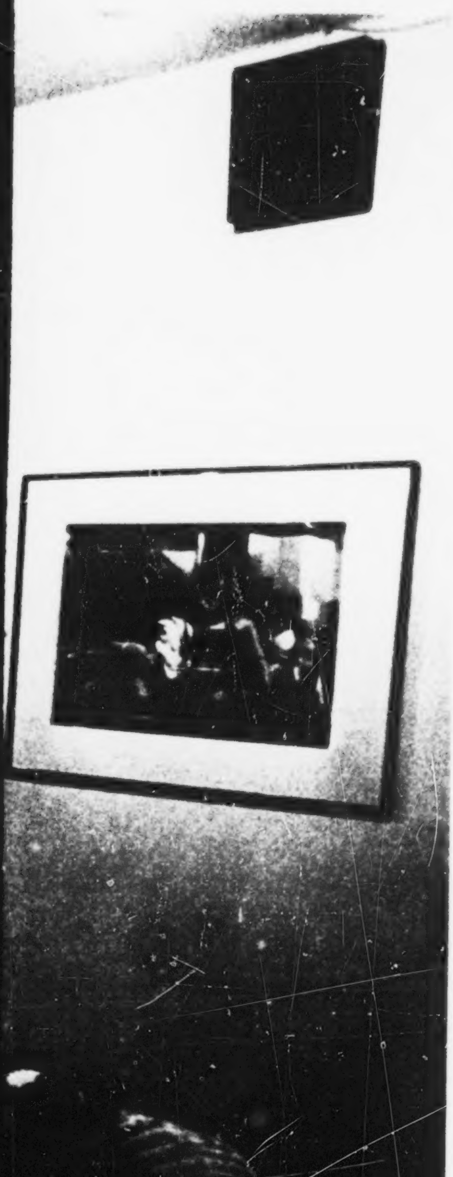
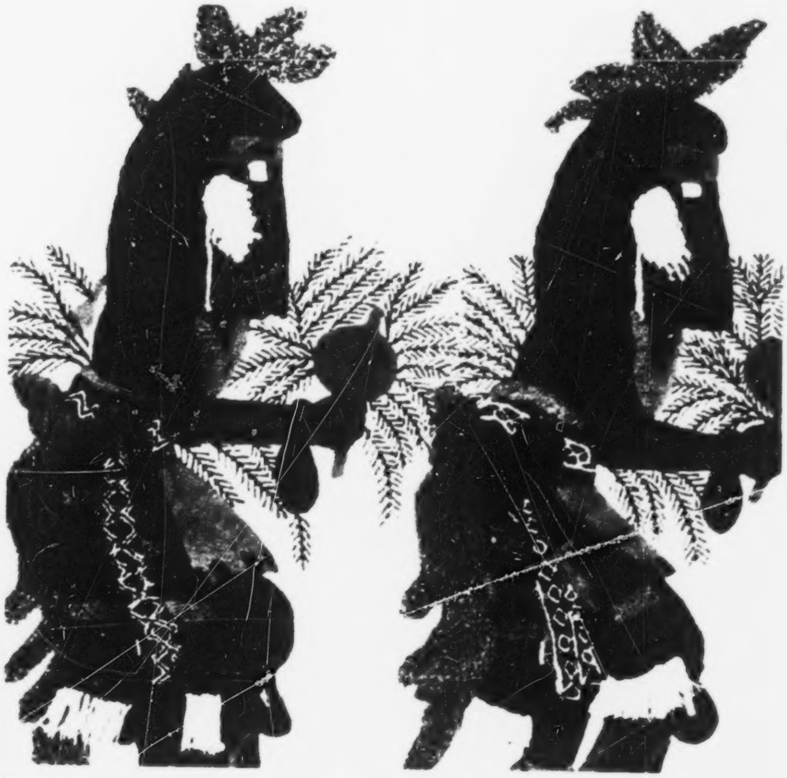


> **"Nursing home residents have health and recreational needs, psycho-social needs and at the same time, aesthetic needs."**



Tapestry by Alice Asmar

that "good" prints and reproductions are displayed and rotated in the patients' rooms. In his opinion, "when people walk into a hospital, they should be greeted with pleasurable sights." The attractive museum track lighting used in all the hallways contributes to what he calls "the art ambiance."

This year's Art 70 Plus exhibit, held in August, featured 200 works by Palmcrest residents. At least 300 members of the families of the elderly attended, along with art critics who scanned the walls for the unusual color and form that signal an undiscovered talent.

For further information please contact:
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Rx

"The primary care physician should regard the recreation and social needs of his isolated elderly patients as equal in importance to their medical needs

Rx For Recreation:

Part of the Doctor's Role

Michael J. Salamon, M.A. and Arlene Nichol*

While the majority of elderly would prefer to live at home, even when placement in an extended-care facility might be indicated, a disturbingly high proportion live voluntarily isolated lives. They refuse to venture from their homes and apartments for a number of reasons. Foremost among these is the fear of attacks. Self-imposed isolation may also result from the belief that they are able to do less as they age. Depression, which is very common in this age group, is also often accompanied by withdrawal.

Other older adults do not leave their dwellings because they are unaware of the social and recreational services that are available to them in their communities. Even though most social service agencies mount strong outreach programs, they are not always successful in attracting clients. One possible reason is that the elderly are unaware of the benefits that may be derived. Most agencies can enrich older adults lives, not only by assisting with entitlements, but also physically and emotionally. This is especially true of senior centers where recreational and socialization activities are provided.

There is one time, however, when even the most stoic homebound individuals venture forth, that is to go for visits to their physician. Recently, one of the authors had to spend time in a doctor's crowded waiting room. Next to her was an elderly woman who had brought along her lunch. When asked if she minded waiting so long, the elderly woman responded, "I like to be here. I like to be with people."

The primary care physician should regard the recreation and social needs of his isolated elderly patients as equal in importance to their medical needs. It is of major importance for the physician to encourage older persons to make use of available services, but physicians, themselves, are sometimes unaware of the kinds of services that exist, or indeed, just how beneficial they may be.

The physician should become aware of relevant programming. This requires a knowledge of the patient's needs in terms of recreational activities, which can be easily obtained by adding only a few more questions to the general history taken from each patient.

When combined with other information about the patient's health, the physician can direct his patient to the proper recreation sites and activities. Many communities now have directories of service providers to the elderly. Local departments of aging are a good primary reference source and should be consulted by the physician. Even when a physician recommends that a patient not leave his or her house, there are recreational and socialization services that may be available such as friendly visitors, telephone reassurance calls, book lending libraries and occasionally a homebound crafts program.

Our experience in serving an elderly population suggests to us that the various kinds of recreation activities offered at senior citizen gathering places, can be divided into four major categories, each with its own unique benefits to the participant.

The first of these is physical activities, which stimulate the body, and improve flexibility, physical dexterity, balance, and blood circulation. They increase muscle tone and lessen some of the stiffness and resulting pain of degenerative joint diseases.

Activities that stimulate the mind make up the category we refer to as mental activities. Included in this group are discussion and social action

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Mrs. Nichol is Project Director of the Homes for Adults Program of the Gustave Hartman YM-YUHA in Far Rockaway, New York.

groups. These activities allow each of the participants to hear other points of view. They are made aware of others' feelings and can share their own views on the topics of the day. Participants also spend time discussing their current problems, and can help one another with solutions and provide positive assistance through warm and encouraging peer support.

The third category includes activities such as games and crafts. These activities are often referred to in disparaging terms as "senior citizen games," yet this programming serves an important twofold purpose. It allows older people to continue working at previously acquired skills, for example, sewing, crocheting, and woodworking while learning new skills, such as macrame or painting. These activities also allow the shy or withdrawn person to be an active participant. The individual can thereby gain from a group-centered program without the threat of having to become active verbally or physically with other group members. The activities in this category are not physically demanding yet they may be used to improve eye-hand coordination and muscle control.

The last of the four categories covers an assortment of activities, including parties, trips, and music and dramatic groups. Trips can be one-day outings or longer excursions. Parties give special recognition to individuals on birthdays and anniversaries. These occasions are socially motivating and allow individuals to share their joy with a larger group. At times the group can take on the supportive and protective role of an extended family. In addition, socially motivating occasions

"Trips encourage older people to see themselves as part of the larger society."

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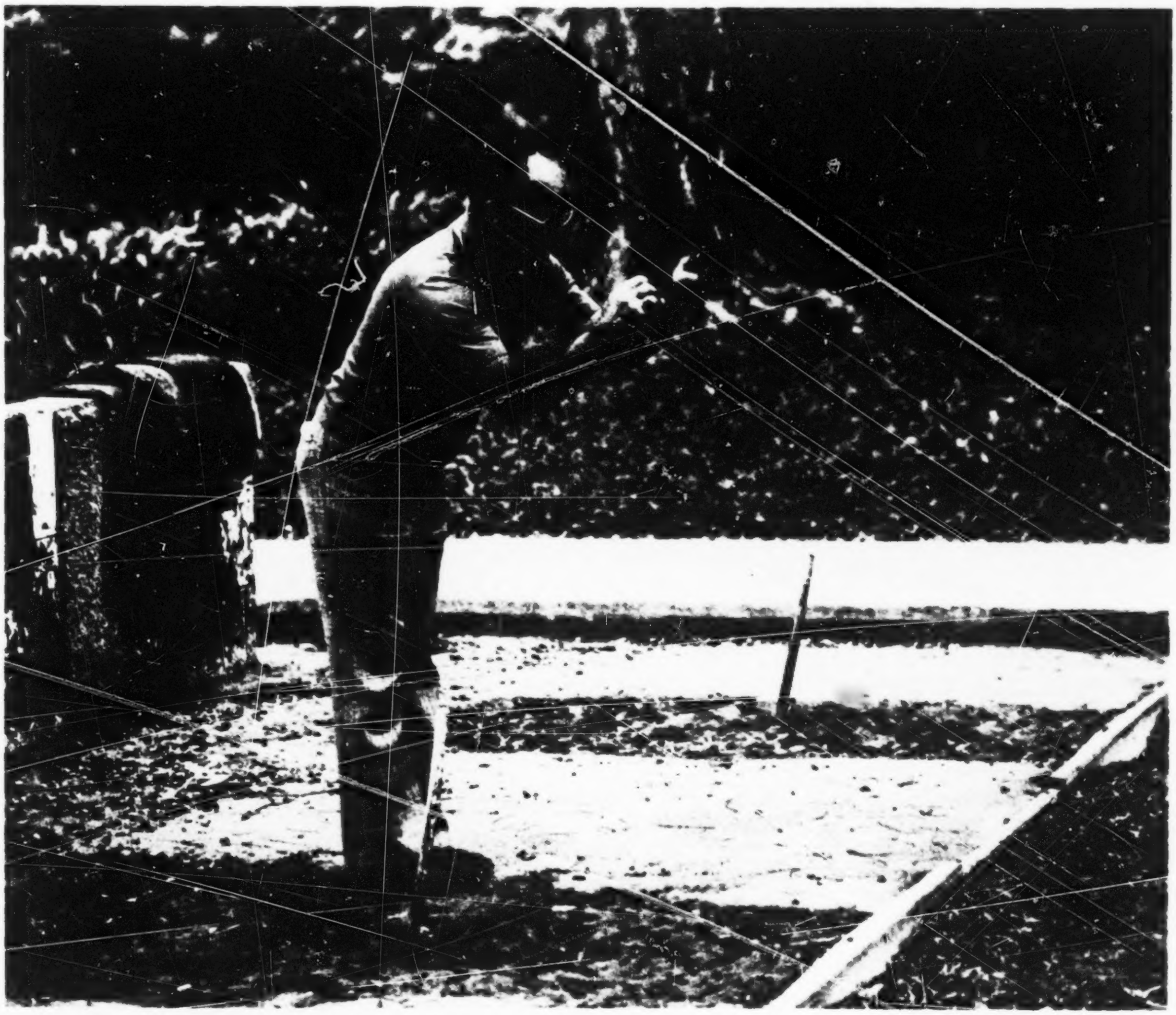

encourage others to become more active so that they too might take part in the group process. Trips encourage older people to see themselves as part of the larger society, a fact that the homebound elderly often lose sight of. This is particularly true for those whose only trip is to their physician's office once every few months.

Recreational activities are an important way to maintain the physical and emotional well-being of older adults. Physicians, as the primary care providers, should consider these services as part of an available therapeutic regimen.

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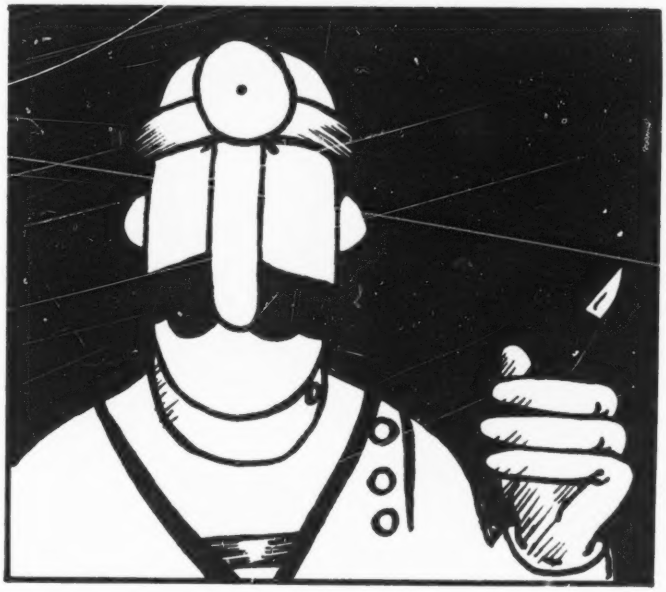
Surgery

> "Traditionally, consultations have occurred because physicians wanted them; now, second opinions may be sought because patients want them"

Surgery and the Elderly

Ann Slayton*



Q: What type of person sees twelve doctors and six nurses a week?
A: The typical American television viewer.

Doctors not only appear frequently on prime time television, but they are characterized as being members of the most successful, humane, and responsive of the professions. "It may well be," conclude researchers at the University of Pennsylvania's Annenberg School of Communications, "that daytime serials are the largest source of medical advice in the United States." They criticize this portrait of doctors—applying the "magic of medicine" to every problem, even ones that have nothing to do with medicine—as "unrealistic" and "idealized."

In real life, doctors know that the practice of medicine is an imprecise art. That is why consultation among physicians is a tradition, almost as old as the practice of medicine itself. The indications for surgery, for instance, are not always precise, and legitimate differences of opinion frequently arise among doctors about what treatment is best.

In recent years, patients have become more insistent about participating in this consultation process, and are less inclined to follow unquestioningly "doctor's orders." In the matter of surgery, more people are taking the initiative to inform themselves about their conditions and seek second opinions when they feel it necessary. Traditionally, consultations have occurred because physicians wanted them; now, second opinions may be sought because patients want them.

The demand among patients to play a more active role in the decision-making process makes some doctors uncomfortable, but most physicians want their patients to understand fully what the problem is and how it should be treated.

**Mrs. Slayton is a writer with the Public Information Office of the Health Care Financing Administration.*

The percentage of patients undergoing multiple surgery during a hospital stay increased from 27.8% in 1970 to 32.6% in 1979. In 1980, 24 million surgical procedures were performed, or 11,000 per 100,000 population. Four of the six most frequent procedures were surgeries on the female reproductive system: hysterectomy, tubal ligation, ovariectomy, and Caesarean section.

Why Have Surgery Rates Climbed?

The escalation of surgical rates over the last decade has multiple causes. The most frequently given reason for the increases is that there are more physicians performing surgery. This is true, but in itself is an insufficient cause. According to a study conducted by the Health Care Financing Administration, increased surgery rates are due to the demand of patients, accessibility of surgical care, and the growth of insurance and other third-party payment sources such as Medicare and Medicaid. There may also be a certain attitude toward surgery as a "once-and-for-all" cure. Certainly, an important factor behind increased rates is the proliferation in the last decade of new diagnostic and surgical procedures, such as the colonoscopy, which permit early surgical intervention for cancer. Improvements in existing technology, for instance the bone cement that is used in hip replacements or the development of the intraocular lens for cataract patients, while contributing to the frequency of certain surgical procedures, make them less risky and more successful in outcome. Finally, major surgical developments, such as the coronary artery bypass for angina pectoris, not only contribute to higher rates of surgery but also are responsible for the escalating overall costs of surgery.

Seeking a second opinion on a recommendation for surgery is especially important for the over-65 population. The elderly have surgery performed and are hospitalized twice as often as the rest of the population. In 1972, the elderly underwent 130.6 operations per 1,000 population. In 1979, that number jumped to 183.4 per 1,000.

Fifteen years ago, one of the most serious problems faced by the elderly was how to pay for increasingly necessary and expensive medical care. Though gaps in its coverage remain, Medicare has largely eliminated this fear, but rising physicians fees and general inflation in the economy have meant that people over 65 are paying for an ever larger share of their medical care in the form of so-called "Medigap" insurance policies that fill in for services not covered by Medicare, and in direct-out-of-pocket costs.

To Have or Not To Have Surgery

Factors determining the need for surgery vary from patient to patient, and according to the condition needing medical attention.

Three procedures — cataract surgery, hernia surgery, and prostatectomy — are among the five most commonly experienced by the over-65 population. Gall bladder removal (cholescystectomy) and arthroplasty — hip replacement are the second and third most frequently performed surgeries among women over 65.

Though surgery can bring about exceptional improvement of a painful condition associated with aging, the risks of surgery increase with age. This is particularly true of major surgery and operations requiring general anesthesia or long hospitalization and recuperation. A general anesthesia, for instance, places an additional strain on the cardio-pulmonary system, which may be weakened in the elderly. Another risk of surgery is a higher frequency of post-surgical infection due to a generally lowered resistance. Depending on individual health status and the procedure done, recuperation periods also may be longer and more difficult than with younger patients.

Every person over age 65 considering surgery should know these general risks. The risks and benefits of individual surgical procedures should be considered carefully.

Cataract Surgery

The leading surgical procedure performed on the over 65 population — cataract surgery — is relatively risk-free. It is usually done with a local anesthetic, and recovery is rapid, but the patient and doctor should agree on the timing of the operation. How much has vision deteriorated from the clouding of the natural lens? Can contract lenses or cataract glasses be worn after surgery? Has the doctor advised not driving at night? To what extent can the condition be ameliorated with glasses? These and other questions are important to the elderly patient who has been advised to have the surgery. Often a second opinion is helpful if the patient is in doubt.

Another decision a person might have to make *before* cataract surgery is whether he or she wants an intraocular lens implant or will be satisfied with wearing contact lenses or cataract glasses. The intraocular lens is a tiny plastic lens that replaces the cataract-clouded natural lens of the eye. It is inserted at the time the diseased lens is removed and, according to the National Eye Institute, offers the best hope for a return to normal vision after surgery. In 1979, 100,000 people or 25 percent of all cataract surgery patients had intraocular lens implants, 90 percent of them between ages 65 and 85.

Ninety-five percent of all routine cataract operations are successful, but it is best, again, for the patient to have a clear understanding of the particular risks and benefits of surgery. Sometimes a doctor will recommend cataract surgery even if the condition is not very advanced and vision is not greatly impaired, if the doctor feels that the cataract condition could lead to some other eye disorder. Usually, however, surgery will be postponed until vision is impaired in both eyes.

In deciding whether to have or postpone the surgery, the patient may want to consult another doctor who can provide more information upon which to base a decision. Some studies have shown, for instance, that aspirin retards the visual deterioration caused by cataracts. One researcher, Dr. Edward Cotelier of Yale University, observed that patients taking large doses of aspirin for arthritic pain have a low incidence of cataracts.

Prostatectomy

Another relatively safe procedure, prostate removal is also performed under a local anesthetic. The prostate, a gland in the male that surrounds the urethra, becomes enlarged with age and sometimes causes painful pressure on the urethra and prevents urine from passing freely. Eventually, the pressure may damage the kidneys.

Removing the prostate is another procedure in which timing is a key consideration. How much discomfort and inconvenience is the person willing to tolerate? Is there any danger of damage to the kidneys? Is another condition likely to be aggravated by the prostate condition? The patient, evaluating such factors with the physician, can come to an informed decision about surgery. Again, should more information be required to make a decision, it is best to get a second opinion.

Cholecystectomy

Removal of the gall bladder, called cholecystectomy, is major surgery, and should not be undertaken lightly by the elderly patient. The gall bladder, part of the digestive system, is a small pouch underneath the liver, in the upper right section of the abdomen. Fatty solids, bile pigment, and lime salts can form stones in the gall bladder or its ducts. Attacks of indigestion or sharp pain in the upper right abdomen are warnings of the presence of gallstones which may or may not be accompanied by infection. Again, whether to have surgery depends on the extent and frequency of infection, and the individual's tolerance of discomfort or pain. Sometimes a change of diet and proper exercise will be sufficient treatment; sometimes surgery is required. Careful consideration of its risk and benefits, perhaps with the aid of another doctor's opinion, can help ensure the best decision.

As with all forms of major surgery, people considering cholecystectomy, should have a clear understanding from their physicians about the condition as well as the risks of surgery and the nature of the recuperation.

Hernia Repair

Over the last decade, hernia repair has become increasingly safer. Still, the rate of infection is higher for those over 65 than for the younger population, and the rate of recurrence is about 15 percent. In considering surgery, the patient must know what other conditions might be aggravated by the hernia, for example, if it causes an obstruction to the intestine. The patient must decide too, what amount of discomfort he is willing to tolerate.

Arthroplasty and Hip Replacement

The third most frequently performed surgery among women over age 65 is arthroplasty and hip replacement. Hip pain and loss of function come from a variety of disorders, such as arthritis and osteoporosis, and hip replacement is considered a largely successful form of treatment. The patient, with her doctor's advice and, if necessary, a second opinion, must decide if the benefits of surgery outweigh the risks. She should satisfy herself that no other medical treatment is available. The patient should have a clear understanding of any restricted activity following surgery, whether she will limp, need to use a cane, or be limited as to walking distance or the ability to climb stairs. There are many factors involved in arthroplasty, hip repair, and replacement which vary from patient to patient, and postoperative complications are more likely in the elderly. Thus, getting as much information as possible is necessary in making a sound decision.

Being a Good Patient

There are several rules-of-thumb that potential surgical patients can follow to make sure that the surgery they are considering is necessary, safe, and worthwhile in terms of cost.

For people over 65 who are relatively healthy and strive to live independently, being a "good patient" means being adequately informed and taking an active role in deciding about their health care. They will find most doctors want their patients to understand what is happening to them, will encourage questions, and will help the patient find another physician to obtain a second opinion on elective surgery.

A person who is advised to have elective surgery should first ask his or her doctor for a referral to a specialist. If, for some reason, the patient does not want the doctor to know he or she is seeking a second opinion, there are several ways to find a second doctor. The patient can:

- Contact the local medical society or medical schools for the name of a doctor who specializes in the field in which the illness falls.
- Call a toll-free number (800-225-6400 and in Maryland 800-342-6600) to obtain the name of the nearest referral group.
- Call the local Social Security Office.
- Contact his or her private health insurance company to see if it has a second opinion referral service.

Once the patient makes an appointment with the second doctor, he or she should call the doctor who recommended surgery and ask that all pertinent records be forwarded. In doing this, the patient avoids wasting time, money, and possible discomfort by repeating tests that have already been done. Of course, if the patient decides to get a second opinion without the first doctor knowing about it, tests will have to be repeated.

Paying for a second opinion should not be an issue for the elderly. Medicare pays for a second opinion, and in some cases for a third opinion, at the same rate that it pays for other office visits, diagnostic tests, lab procedures, or hospitalization, if required. Since Medicaid payments vary from State to State, the patient should check with the local welfare office to see how much the program will pay.

If the patient decides in favor of surgery, it may be worthwhile to discuss with the doctor the possibility of having surgery on an outpatient basis. Approximately 70 percent of hospitals in metropolitan areas perform outpatient surgery.

OPINION #1
OPINION #2
OPIN ON # 3

and there are a growing number of freestanding ambulatory (outpatient) surgical centers. About 100 surgical procedures, including cataract surgery and some hernia repairs and orthopedic procedures, can be done safely without hospitalization. Not only is outpatient surgery less time consuming, it is also less expensive, and much less stressful for the patient. Medicare now pays 100 percent of the costs of the outpatient facility, though the surgeon's fee is reimbursed at 80 percent unless he agrees to accept assignment from Medicare.

Know the Answers

Before agreeing to any non-emergency surgery, people should know the answers to these questions:

- What does the doctor say is the matter with you?
- What operation does the doctor suggest you have?
- What are the likely benefits to you of the operation?
- What are the risks of the surgery, and how likely are they to occur?
- How long is the recovery period, and what is involved?
- What are the costs of the surgery and recovery period?
- What is likely to happen if you don't have the operation?
- Are there any alternatives to surgery that could be tried first?

Being a "good patient" means being informed about one's medical problems, and being able to get enough information about recommended surgery or alternative medical treatments to make the best decisions. These guides are just as important for the trusted family members and friends whom the elderly depend on for assistance in making health care decisions. The Department of Health and Human Service's Health Care Financing Administration has a booklet that can help patients and their families make good decisions about elective surgery. It can be obtained by mailing a request to:

Surgery
HHS
Washington, D.C. 20201

Experience Exchange

Medical Students Age Instantly and Learn Patience*

Aging is an inevitability which we must all face, and a first-year course at the Medical College of Pennsylvania is making students more sensitive to the problems which sometimes accompany it. One part of the course requires students to age instantly; for some students, Vaseline on their spectacles cloud sight, for others, taped fingers simulate arthritis, rubber gloves dull their sense of touch, earplugs muffle sounds, and wheelchairs and walkers hinder mobility. For the first time, routine events like eating lunch, catching a bus, or taking notes in class overwhelm them.

Unable to function at their usual pace, last semester's students felt angry, frustrated, and isolated. That was the point of the exercise. "It's frustrating to lose a sense you're used to having," student Valerie Hendrzak said. "What's scary is your dependence on other people," commented Robin Lerner. "When asking for help, there's the fear that someone may refuse to help, or worse, become patronizing," said Deborah D. Shain, course co-ordinator, who also participated in the exercises.

Students in wheelchairs or with walkers were not the only ones who relied on assistance to maneuver through their daily errands. Those with limited vision and numbed fingers trusted the grocery store cashier to return correct change. They could only hope they had paid with a $5 bill, instead of a $20.

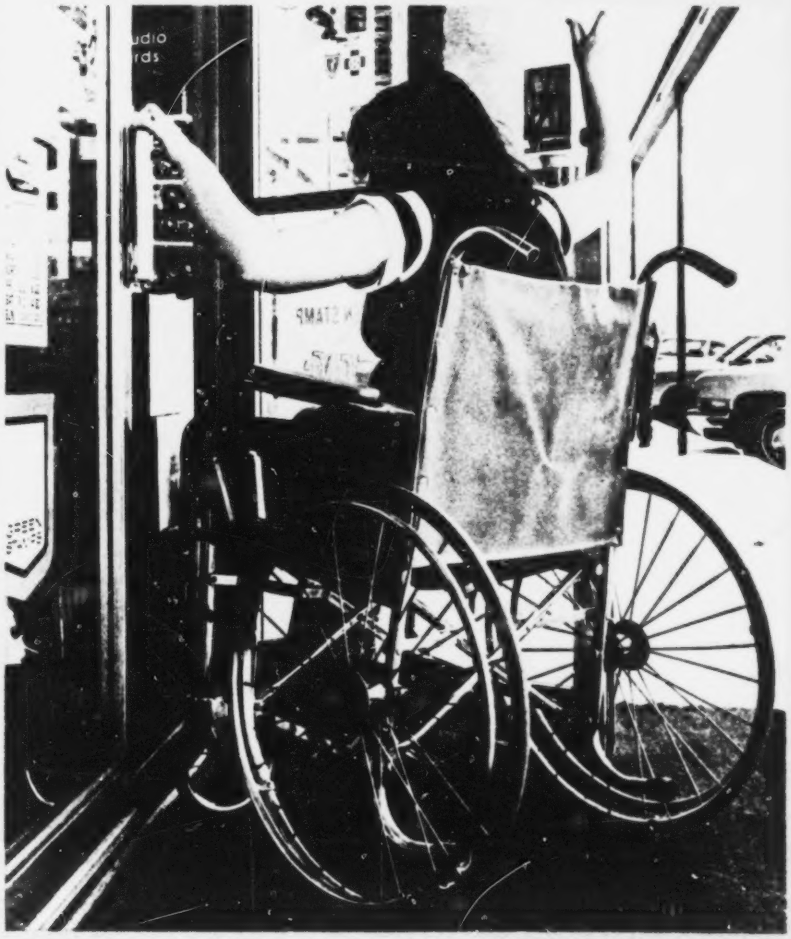
Making phone calls frustrated students as well as those waiting in line behind them, said Ms. Shain. "Just getting a dime out was difficult. Hearing on the phone was almost impossible. Some students felt pretty dumb. A line formed of people waiting to use the phone. The students got a sense of 'hurry up,' from the people behind them."

Students with plugged ears turned the volume up to listen to television. Ms. Hendrzak recalled that "younger people would look at us and ask: 'Why do you have the TV on so loud?' "

Other classmates, using walkers, found bus rides aggravating. According to Ms. Shain, "Some missed the bus, or the bus doors closed before they could get on. If they did get on, the bus started before they were seated. The bus aisle was too narrow for their walkers. They felt clumsy and genuinely uncomfortable."

The "handicapped" students felt further alienated as other people averted their eyes — or stared. "You feel that you're being watched," Ms. Lerner said. "For older people, that can be very frustrating."

Routine tasks sapped students' patience. "It took four times the amount of time it usually takes to write references from a card catalogue. I ended up using



my teeth to pull off a pen cap," said student Carol Most Levin, whose hands were bound. "I wanted that tape off my hands."

Although the tape and other impediments have been removed, the effects of old age linger. The future doctors now look upon the elderly with greater empathy. "They're not a different type of person than we are; they're just an older youngster," commented student George Zubach.

"It's important to treat the whole person, instead of just the illness," Ms. Lerner said. "With so much science to learn, we sometimes forget the importance of compassion. It's important to take a few minutes to talk to them."

"A lot of patients don't communicate their worries to you," observed Ms. Hendrzak. "They're worried that they'll be put in a nursing home, and, if they don't have a will, to whom they're going to give their things."

"As a student you learn to find what is wrong, and how to fix it. Then, you fix it," Ms. Levin said. "You can't always do that with the elderly. That takes getting used to."

According to Ms. Shain, students realize they should "slow down, speak clearly, and let the older person articulate the rage they felt just getting to the office. They learn to touch a person who is blind and say: 'Well, Mr. Smith, I'm going to be using an instrument that's 6 inches long and it's going to be cold.' It's pretty hard to be punitive or critical, when you've been through it yourself."

Further information on this course is available from:

Deborah D. Shain
Medical College of Pennsylvania
Philadelphia, Pa.
Telephone: (215) 842-6895

******This article was written by Michele Meyer.*

Nursing Home Residents Savor a New Kind of "Apple"

Would elderly patients play computer games if the games were available to them? The answer, according to Shulamith Weisman, Director of Human Services at the Hebrew Home of Greater Washington, is a resounding "yes!" Last year, Mrs. Weisman was talking to the owner of an Apple computer who is a psychiatrist. She hypothesized that since the general population, young and old, is crazy about computer games, the very old would also enjoy playing them. The psychiatrist was skeptical. "Old people don't like new technology," he said. "My mother doesn't even like to use a touch-tone telephone."

Nevertheless, Mrs. Weisman persuaded Joe, the psychiatrist, to bring his computer into the Hebrew Home where the average age of the residents is 85. Carrying his computer and assisted by his two children, ages 8 and 9, Joe programmed it as follows: HELLO, MY NAME IS APPLE. PLEASE TYPE YOUR NAME. VERY GLAD TO MEET YOU, . . .

Residents of the fifth floor, most in wheelchairs, seeing something unusual going on in the living room, crowded around the computer. Everyone wanted to try it out. The first gentleman, Bill, 89, typed his name and was rewarded by: VERY GLAD TO MEET YOU, BILL. Bill broke out into a huge grin and said, "Do all of you see that? This machine likes me!" From that moment on it was obvious that America's love affair with the computer extended to the elderly. The other residents had similar positive feelings about the experience.

Mrs. Weisman then contacted Georgetown University's School of Community Medicine where Research Associate Dr. Elaine Eckles agreed to help design a simple research instrument which would indicate whether specific infirmities (poor vision, hearing, poor memory, tremors, history of stroke, etc.) would interfere with the ability to use the computer. Bernie Benson of the Washington Apple Pi Club adapted three games to be tried with the elderly. His adaptations included slowing the games down, making the figures larger, and reducing the number and complexity of the visual characters.

Everything was now ready for a small research project to discover whether or not the elderly would be stimulated by and find enjoyment in computer games.

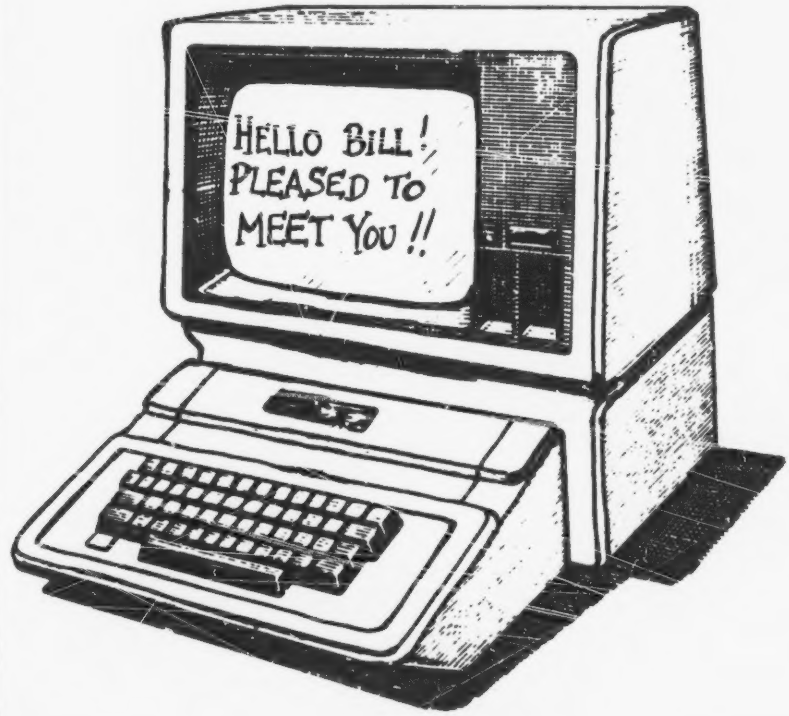
All that was lacking was a computer. This problem was solved when the Apple Corporation generously agreed to provide one on loan for 3 months.

Results thus far have been impressive. All 35 residents of the Hebrew Home who have already played the games have reported having fun. One lady says, "It clears the rust out of my brain." Almost every participant had at least one relative who works in the computer field or owns a computer, so a common remark after each session was "Wait till I tell my son (grandson, niece) that I know how to work a computer." Having access to a computer made these elderly people feel they were participating in the age of technology. Most residents had seen T.V. commercials featuring young people having fun playing computer games so that little persuasion was needed to get them to try the games.

A major problem uncovered by the project was that there are no commercially available games which are suitable for the elderly. The computer industry should be made aware of the potential market for games and programs which appeal to the older person. Designers would have a free rein as long as the programs could be read easily, and not all of them required speed and quick reflexes.

Most of the messages which elderly nursing home residents receive from society, the community, the institution, and even family and friends, tell them that they are on an irreversible downhill course which will end in senility and physical deterioration. Learning a new skill, especially one which is glamorous and upbeat has helped the Home's aged clients develop an improved self-image. Residents who played the games reported that they were surprised at their ability to concentrate and coordinate hand and eye. It is interesting that even those who are arthritic, hemiplegic (paralyzed on one side of the body as a result of a stroke), or suffered mild to moderate senile dementia mastered some of the games.

This small study is just a first step in the adaptation of computer games for enjoyment and benefit of the elderly.


HELLO BILL!
PLEASED TO
MEET YOU!!

More information is available from:

Shulamith Weisman
Director of Human Services
Hebrew Home of Greater Washington
6121 Montrose Road
Rockville, Maryland 20852
Telephone: (301) 881-0300.

State & Community News

Electric Co. Customers Help Kansas Elderly To Pay Utility Bills

Last February, a request went out to the customers of the Kansas Gas and Electric Co. to add $1 to their monthly payments for utility bills to support Project Deserve, a fund to provide energy assistance to the low-income elderly.

Despite a rise in their own bills, the customers responded generously. By the fall, they had contributed about $64,000 to help pay the gas and electric bills of elderly people — many of whom have medical problems.

The energy assistance fund started last winter with an initial $25,000 contribution from Kansas Gas and Electric stockholders and $11,000 in donations from the utility company's 2,000 employees. The Kansas Red Cross, which is supervising distribution of the funds, also received about $22,500 in direct donations.

As of October, a total of approximately $112,500 had been collected, and Project Deserve had assisted 676 elderly people and their families.

The funds have been distributed in 23 counties in southeastern Kansas by volunteers from 12 local Red Cross chapters. The volunteers are supervised by Red Cross caseworkers in assessing the financial needs of the elderly. A special committee of Red Cross volunteers in Wichita, home of the Kansas Gas and Electric headquarters, monitors the entire project.

"Contributions from the utility customers are not used to cover any administrative costs," says Mike Wemmer, Director of Emergency Social Services for the Red Cross' Midway-Kansas Chapter in Wichita. He notes proudly that promotional materials urging Kansas Gas and Electric customers to donate use the motto "$1 in is $1 out" to help the elderly. "About $7,000 to $7,500 is coming in each month from customers," he reports. The project's success has prompted many inquiries from gas companies and Red Cross chapters in other States, including Tennessee, Arizona, Missouri, and Arkansas.

Explaining how Project Deserve works, Mr. Wemmer points out that although recipients are selected primarily on the basis of financial need, there are no rigid income guidelines, restrictions on amount of aid, or the number of times an elderly person may receive help.

"The basic criteria are that the recipient be 60 or over and the head of a household, or that person's spouse. We also look at medical factors; for example, a doctor may say that an elderly person must have hot water in the summer to treat a medical condition."

For most recipients, payment of summer hot water bills was discontinued last April, because the project staff was concerned about building up a reserve fund for the winter months. "Last winter," Mr. Wemmer recalls, "we spent over $1,000 a day but only $500 was coming in."

"This year, we wanted a reserve of at least $20,000, because we knew we'd be helping many elderly people to get their gas turned back on in the fall." According to Mr. Wemmer, it is not uncommon for low-income elderly to allow their gas to be shut off in early summer. "We also find that the elderly people in this part of the country are very self-sufficient and reluctant to ask for help — so they may cut back on meals or pay only part of the rent in order to meet utility bills." Fortunately, the project is allowed to provide aid for food, rent, and "other indirect energy-related expenses."

Most of the money, however, goes to pay for gas heat, even though, ironically, Kansas Gas and Electric hasn't sold gas for many years. The company simply retains the word in its name for the sake of tradition.

This winter, the electric company is counting on the continued generosity of its customers and their concern for the elderly people who are forced to keep the thermostat low — too low to combat wind and cold in Kansas. "It's very common," says Mr. Wemmer, "for it to be in the teens in January and February and for the wind chill index to fall below zero."

For further information, contact: Mike Wemmer, Midway-Kansas Chapter of the Red Cross, 707 North Main, Wichita, Kan. 67203. Telephone: (316) 265-6601; and Robert Rives, Attn. Project Deserve, Kansas Gas and Electric Co., P.O. Box 208, Wichita, Kan. 67201. Telephone (316) 261-6611.

Rural Rhode Island Town Tackles Lack of Services For the Isolated Elderly

In 1976, the one physician who had served rural Hopkinton, R.I., and three adjacent country towns retired, leaving residents, and especially the elderly, with a 20-mile trip to the nearest hospital for medical care.

Brenda Pukas, a local nurse got together with other residents to discuss what could be done to make health services accessible to the four towns. The best solution, the group decided, was a community health center that would bring a wide range of assistance to townspeople — medical, nutrition, dental, family planning, and counseling services.

Initially, the center, called Wood River Health Services, was located in a small converted grocery store where the attending physician saw patients two evenings a week. Last May, the center moved to a new 6,000 square foot building, and doctors are now available 12 hours a day.

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The center's 30-member staff includes Mrs. Pukas, who assumed the job of administrator, two National Health Service Corps doctors, a family nurse practitioner, a family planning specialist, two nutritionists, a dental hygenist and a social worker. A pediatrician, podiatrist and surgeon periodically come to the center.

Mrs. Pukas recalls that after the center opened, she and three VISTA volunteers quickly became aware that there was a great need for special services for the elderly. Determined to find a solution to the problem — especially to the need for home health care — Mrs. Pukas went to the Rhode Island Department of Elderly Affairs. She presented an idea for a comprehensive service program for the elderly and received help in 1979 in obtaining a 3-year, $300,000 "Model Projects" grant, funded under the Older Americans Act.

The model project, which ended last January, "was designed to provide comprehensive care to the elderly through one agency," explains Kathleen McKeon, Assistant Coordinator for Aging in Rhode Island's Department of Elderly Affairs in Providence. She says that when the grant was awarded, Wood River Health Services "was a very different kind of agency, because of its rural location and the fact that there were very few services down there."

Describing the economic status of the rural elderly residents, Ms. McKeon notes that while they are not exactly impoverished, they often live in old homes that are expensive to heat and maintain. "They may have had a garden and raised some chickens at one time, but are too frail to do that anymore," she observes, adding that some of the elderly could be described as "land poor."

Staff at the health center note that in an area where homes are scattered, the elderly have to cope with isolation on top of financial difficulties and a lack of health and social services.

Brenda Pukas says that home health and personal care is one of their greatest needs. The nurse practitioner also notes that many of the elderly have incomes just high enough to make them ineligible for home health care reimbursed by Medicaid and social services provided by other federally-funded programs.

"When we received the grant, we added a strong outreach component," explains Mrs. Pukas, "because there was a great need among the elderly for information and referral." She says the demonstration was a flexible program designed to meet the elderly's individual needs — from medical treatment to respite care and friendly visiting. "Elderly people isolated in the woods may need someone to check on them periodically or if they are hospitalized, to look after their homes."

"When the project was fully operating, we had 10 staff people as well as volunteers," notes Mrs. Pukas, but now that the demonstration grant has ended, she says the program for the elderly "has wound down." The program, which serves a five-town area, currently has one full-time outreach worker and a second outreach worker, senior companion, and home health aide who work part-time. A geriatric nurse practitioner, who was on the payroll full-time during the project, is volunteering her services until the center can find new sources of funding.

Although the amount and extent of care has been reduced, key services are now being offered to the elderly that were nonexistent in Hopkinton in 1979.

Outreach worker Helen Terrien says her role "is to find elderly people who need services — medical treatment, personal care, emotional support to deal with loneliness, and intellectual stimulation." She says the outreach workers refer the elderly to agencies that can help them, such as those providing housekeeping assistance, and keep them informed about tax rebates, emergency fuel aid, and Medicare.

"We also provide respite care which is greatly appreciated when you have a spouse or a daughter who is on duty 24 hours a day with a bedridden or homebound person," comments Mrs. Terrian.

She says functional assessments are done for each patient served by the center to determine ability to live independently, and visits are scheduled with the internists, the dental hygenist, the nutritionists, and the podiatrist.

Among the many problems faced by the elderly people in the area, Mrs. Terrian says loneliness, depression, and the prospect of having to move to a rest home are the worst. "But with our personal and respite care . . . and our visits and phone calls, we are trying to keep people in their own homes."

"In every way," concludes Mrs. Terrian, "we try to befriend our people, to be caring and loving . . . We are considered not just a medical services provider, but a friend."

For further information contact: Wood River Health Services, Route 3, Hope Valley, R.I. 02832. Telephone: (401) 539-2461.

Vermonters Enjoy New Type of Team Spelling Contest

Benevolent . . . precipice . . . irrepressible . . . amethyst . . . and mayonnaise. Seniors in Rutland, Vt. and White Plains, N.Y. recently knitted their brows over these and other tricky words in what was probably the first interstate spelling contest for senior citizens.

Groups from both towns prepared for the event by participating in local contests that adopted a team approach to spelling competition introduced by Dr. Allen Sher, a professor of education at the College of St. Joseph the Provider in Rutland. Used successfully with school children, adults, and seniors in Vermont and other States, the team approach is less nerve-wracking and more fun than the traditional spelling bee. "Everyone remembers the disappointment of having to sit down and drop out after missing a word in a school spelling bee," says Dr. Sher.

In the team approach, the competition goes for twelve rounds, and no one is eliminated. The contestants have a chance to spell a word in each round, scoring points for their teams if they are correct. If they are wrong, they receive no points for that word but continue in the match. "It's like a baseball game," comments Dr. Sher. "Just because you ground out, fly out, or strike out, you are not out of the game."

The words asked in the competition are drawn from a national standard spelling list, available from Dr. Sher, but bonus words not on the list can earn seniors extra points. The seniors on the 4- or 5-member teams are not the only ones testing their skills and having fun. Dr. Sher says the audience gets very involved, spelling the words silently, applauding when a senior gets past a spelling hurdle or laughing good-naturedly when a contestant falls into a spelling trap.

The team competition has been used by groups of seniors in New Jersey and New York, and in Fern Hill, Vermont, a team of elderly people from an apartment complex for seniors pitted their spelling prowess against seventh and eighth graders. In fact, the Vermont State Department of Education is encouraging the team approach and has conducted a statewide spelling contest for the past three years, with 184 teams competing throughout the year to enter the finals last spring.

Since the spelling competition combines mental stimulation with team work and audience enthusiasm, Dr. Sher sees it as a good activity for congregate meal sites, senior centers, and associations of retired people.

If you think that the national standard list of words sounds easy, ask your friends to try some of these: daffodils, chandelier, rhinoceros, lachrymose, titillate, misogynist and mausoleum.

For a copy of the master spelling list and the contest rules, please write to: Allen Sher, 62 Meadowbrook Rd., Rutland, Vt. 05701. Telephone: (802) 775-1159.

Oklahoma's 6,000 Home Care Providers

For the frail and disabled elderly, daily help, concern, and skilled care from another well older person can mean the difference between living at home or entering a nursing care facility.

A corps of 6,000 home care providers — many of them retirees — are making this important difference in the lives of about 7,000 disabled and elderly people in Oklahoma through the State's Non-Technical Medical Care (NTMC) program. NTMC is part of the Medical Units of Oklahoma's Department of Human Services (DHS).

The program makes home and personal care assistance, financed by Medicaid, available to eligible disabled and elderly people who have medical problems requiring regular attention and a physician's care. The paraprofessional providers, who receive a fee of $13.93 (includes FICA) a day for a minimum of 3 hours work, are trained and supervised by 83 NTMC registered nurses stationed in county DHS offices throughout the State.

"Our providers are usually in the 50 to 70 age range — low-income or retired people who are doing this work to supplement Social Security, a widow's pension, or whatever they are getting," notes Dora Stohl, State nursing supervisor for the NTMC program. The supervisor adds, however, that she has found that money is not the key consideration for the providers. "Most of them are retired, but they don't want to be 'put on the shelf' — they want to do something useful and worthwhile," says Miss Stohl.

Referred by doctors to the NTMC program, the elderly patients may require an exercise regime, supervision in taking medication or preparing special diets, and assistance with household chores. Some clients are completely bedridden.

"Our purpose as nurses is to provide supervision and training to the providers who are in daily contact with the elderly," says Miss Stohl. The providers are given a 20-hour basic home nursing course, which covers preparation of special meals, supervision of medication, techniques of providing personal care and rehabilitation, and ways to motivate the elderly to cope despite their illnesses and disabilities. "We also cover the aging process, and have speakers from our Unit on Aging in DHS," notes Miss Stohl.

Early in the program, a basic home nursing manual was developed for the providers to use as a reference when they are in the homes of the elderly. Since some of the NTMC nurses have had limited teaching experience, the manual has also been useful in serving as a basis for construction of lesson plans. The most recent improvement in the training course was the addition of 42 audiovisual lessons in home care, based on the manual and illustrated with humorous caricatures of patients and providers.

The NTMC program also offers in-service training classes to the home care providers. "These are classes on diseases and conditions covering arthritis, high blood pressure, etc.," explains Miss Stohl. She says the classes "make the providers more knowledgeable about their own health and help them to take better care of their patients."

An NTMC nurse visits each patient as needed or every 2 months. Providers say they are reassured to know that the nurse will be checking on the patient's progress and will be available to answer questions on problems that arise. From the nurses' point of view, the detailed information on the patient entered by the homecare provider on her task sheet results in the development of the best possible treatment plan, which is based on the physician's orders and the nurse's assessment of the patient's needs.

Although a relative of the elderly patient cannot serve as a provider, a friend or neighbor may apply for the job. "We frequently have cases of a friend taking care of a friend," says Miss Stohl, "and we always try to match providers and patients from the same neighborhoods." If the patient does not have a particular person in mind, the program supplies the elderly person with a list of providers to interview.

Miss Stohl points out that the $13 a day fee purchases more than 3 hours of help. "Most of the providers work 4 to 5 hours, some work 8, and a few even live in with their patients."

Statistics on Oklahoma's NTMC program for January, February, and March 1982 showed a total cost of $7.3 million, with $5.9 million going for providers' fees. "Our average monthly expenditure per elderly patient is $350.75," notes Miss Stohl. She says this compares to an average monthly cost for nursing home care in Oklahoma of $782 a month.

There may be no way, however, to put a price tag on the benefits to the elderly. In the words of an NTMC district nursing supervisor: "They tell us they would be dead or alone in a nursing home if it weren't for our providers."

For further information on the program, please write to: Non-Technical Medical Care Program, Department of Human Services, P.O. Box 25352, Oklahoma City, Okla. 73125.

Pennsylvania Survey of 70 Health Care Centers

According to a recent report tabulating the results of a 1978 survey of 70 nonprofit health care centers in Pennsylvania, the typical fee charged by the centers for a routine visit ranged between $7 and $12.99.

Complete financial data from 41 centers that offered strictly medical care showed average actual center costs per visit of $26.00 compared to average per visit revenues of $10.25. The report says these figures and other cost data from the survey provide evidence of the financial struggle faced by nonprofit health care centers in their attempt to improve access to health care among low- and moderate-income groups.

The report or chartbook, *A Graphic Look at Pennsylvania's Nonprofit Primary Health Care Centers*, was compiled by researchers from the Department of Agricultural Economics and Rural Sociology at Pennsylvania State University who conducted the survey. The chartbook includes data on size of facilities, number and type of center personnel, range of services offered, patient care practices and sources of revenue.

The report notes that the centers had been in operation an average of only about 5 years, reflecting the relatively recent support given to their development — first in the 1960's by the Neighborhood Health Center program in the Office of Economic Opportunity and then in the early 70's by such programs as the Rural Health Initiative in HHS.

Of the 70 centers that participated in the survey, 43 were considered to be rural and 27 urban. Throughout the report, comparisons are made between the urban and rural centers and also between the 47 centers that were owned by independent nonprofit corporations and the 23 that were hospital-owned.

The report notes that of 49 centers submitting complete information on finances, about 10 incurred total patient costs of $500,000 or more annually but only 1 received that amount in patient revenues. Approximately 21 centers received revenues of $100,000 or less, with only about 5 reporting that their patient costs were that low. All but 2 of the 49 centers required grants or similar sources of income to continue their operations.

Data provided by 58 centers on the proportion of patients having third party coverage showed that one-third of the clinic patients were covered by Medicaid and 15 percent by Medicare. The report says these statistics "suggest that the centers were serving a disproportionately large share of elderly and low-income persons." About one-quarter of the patients had other third party coverage and 29 percent had no insurance at all.

According to Dr. Sam Cordes, one of the authors of the report, the health centers are serving patients whose needs might otherwise not be met. "The centers are typically located in medically underserved areas. In addition, these areas often have a high proportion of elderly, of low-income residents, and of people with no health insurance," says Dr. Cordes.

He notes that the centers also serve an important function because their philosophy is somewhat different from the private practice model. "There's more emphasis on preventive services and on health promotion and maintenance, and the services often include outreach, transportation, and health education.

"The health centers," he comments, "are delivering a different product — probably a more costly product, but the extra cost is worth it from the standpoint of the society as a whole."

Commenting on the financial difficulties of the centers, Dr. Cordes notes that insurance doesn't reimburse for many the services they provide. He also says patients present more health problems than the average patient coming to a private doctor with a specific condition. Dr. Cordes points out that even through the patient at the center usually requires more physician time and medical resources per visit, the insurance reimburses at the same rate as it does for an office visit to a private doctor that usually requires less time and the services of a smaller number of medical personnel.

Copies of the report may be obtained free from Dr. Sam Cordes, Department of Agricultural Economics and Rural Sociology, Pennsylvania State University, University Park, Pa. 16802.

Postmen To Watch Over Aged Living Alone In Carrier Alert Program

The postman has always been a reassuring presence, someone who marks the rhythms of the day, nods a friendly hello, and serves as a reminder of earlier times when life was not dominated by the machine.

Recently, postmen across the country were invited to extend this reassurance to keep a watchful eye on elderly and handicapped people living alone through a program called "Carrier Alert."

Endorsed jointly by the Postal Service and the National Association of Letter Carriers (NALC), Carrier Alert is a program in which postmen monitor the mailboxes of elderly and handicapped people for accumulations of mail that might signify a sudden illness or injury.

Following procedures that would be established locally by postmasters, NALC union representatives, and a sponsoring social service agency, postmen would report worrisome accumulations of mail to the service agency for appropriate follow-up.

Cities and towns that decide to establish the program would encourage the elderly to file a registration form with the social service agency that would include the names of relatives or friends to contact in case of an emergency. After the post office was notified of the registration, the letter carrier would affix a decal to the resident's mailbox to indicate participation in Carrier Alert. Residents would be asked to notify Carrier Alert of planned vacations of more than a few days.

The program has received the full support of AoA and the Red Cross and United Way — two organizations that have served as sponsoring agencies for the alert system in several areas of the country where it has been established successfully. In New York City, where an "Early Alert" program was set up in 1975, the city's Department for the Aging receives reports from concerned letter carriers.

At ceremonies marking the joint commitment of the NALC and the Postal Service to a national Carrier Alert System, David A. Rust, Deputy Commissioner of AoA, noted that "well over 7 million people over 65 are living alone in their own homes — 80 percent of them women." He said half of these elderly people are over the age of 75. "To these homebound elderly and to handicapped people of all ages Carrier Alert will bring . . . a sense of not being all alone," Mr. Rust said. The Deputy Commissioner noted that AoA has sent a memorandum to its 57 state and 600 local area agencies on aging encouraging them to take part in Carrier Alert and has supplied them with guidelines on how to establish the program. Guidelines have also been sent by the Postal Service and NALC to postmasters and presidents of local branches of the union.

Also present at the ceremonies was NALC President Vincent R. Sombrotto who stressed the role of the letter carrier as "a friend to all Americans." Mr. Sombrotto noted that for years thousands of mailmen have conducted their own "informal" Carrier Alerts. Among recent incidents reported to the Postal Service: In May, 1982, a letter carrier in Spartanburg, S.C., hearing a faint noise inside the house of an elderly lady who lived alone, shouted, heard a reply, looked in the window and saw her lying on the floor. He called the rescue squad and stayed with the woman until they arrived. The letter carrier later learned that she had suffered a heart attack the previous day and had crawled to the door to await his appearance the next morning. Similar incidents, involving heart attacks, injuries, and illnesses of elderly people, occurred last year in at least six other cities and towns.

Although heroic feats by letter carriers do occur, the Postal Service and the NALC are stressing that postmen participating in Carrier Alert are not expected to be on-the-spot rescuers or

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life-savers. Their role is to be on the look-out and to report to the sponsoring social service agency when they are worried about uncollected mail at the home of an elderly person.

Under New York City's procedures, the postman reports to Department of the Aging staff. Staff then call the resident and if they receive no answer, call friends or relatives listed on the person's registration form to determine why the mail may have piled up. If there is no satisfactory explanation, a social service staff member is sent to the residence and if the worker can't gain access and learns nothing new from neighbors or the apartment superintendent, the police are called.

It is hoped that the Carrier Alert system will add an element of daily reassurance to the lives of the frail and homebound elderly that will be backed up by a network of community agencies that are ready and willing to help.

The Postal Service is urging customers not to call local post offices to find out about Carrier Alert but to watch their local news media for announcements of sponsorship of the program by an agency in the community.

New Job Alert For Personnel In Aging

Employers anywhere in the United States who have job vacancies in the field of aging may list them free of charge in the WGS JOB ALERT, a monthly publication of the Western Gerontological Society. Both professional and paraprofessional openings may be listed. Send announcements and job descriptions to WGS JOB ALERT, 833 Market Street, Room 516, San Francisco, Calif. 94103, or call (415) 543-2617. JOB ALERT is published on the 15th of every month.

Gerontology professionals and paraprofessionals seeking information on positions available and career opportunities can subscribe to WGS JOB ALERT. Subscriptions for WGS members are $9 for six issues or $5 for three issues; non-members may subscribe at $11 and $7 respectively.

Psychotherapy Does Help the Elderly, Study Finds

A large percentage of elderly men and women suffer from emotional problems but when given psychotherapeutic counseling, they will respond as readily as people in other age groups.

This is one of the observations made in an interim research report prepared by the Jewish Counseling and Service Agency of Metropolitan New Jersey (JCSA), based on the agency's experience in counseling 500 elderly clients and their families. Almost half of the elderly clients — 47 percent — suffered initially from depression, the JCSA found.

The agency is one of 15 counseling agencies that have received research support from the Medicare program in HHS' Health Care Financing Administration to test the hypothesis that sustained psychotherapeutic support services for the elderly can prevent premature and inappropriate institutionalization. The three types of agencies participating in the 2-year project, which will end in April, 1983, are community mental health centers, hospital day care treatment programs, and family counseling agencies, such as JCSA.

The preliminary findings of the JCSA on treatment of elderly clients were presented by Martin Roth, coordinator of JCSA's Services to the Aged, in a research report he made to the Annual Conference of Jewish Communal Services in Minneapolis last summer.

In the report, Mr. Roth noted that the 500 clients included in the JCSA study are, on the average, 80 years of age, frail, poor, and on fixed incomes, with Social Security the sole source of income for 72 percent of the group.

Most of the men and women are being treated by JCSA in individual psychotherapy in their own homes, while others receive family-centered counseling or group therapy.

Despite the high incidence of depression, which Mr. Roth says is "the aged's emotional response to the loss of a family member or friend," the aged clients were found "to function emotionally at a higher level than expected" and only a small number — 8 percent — suffered from organic mental disorders.

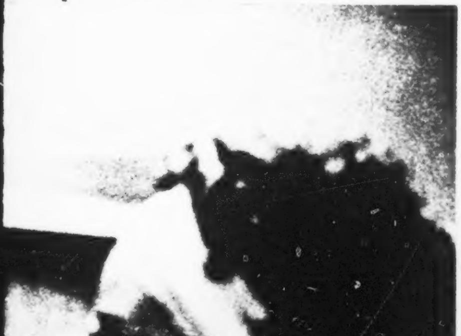
According to Mr. Roth, the agency's experience in treating numerous cases of depression and other psychological problems within the client group is that the elderly respond as well as younger age groups to treatment from a social worker. Mr. Roth believes that "psychotherapy can enhance the chances of the aged person's remaining longer and more independently in the community."

Herbert Bernstein, Assistant Execu-

tive Director of the JCSA, notes that the agency served 2,100 Jewish families last year, mainly in Essex County, and that slightly more than 500 families either had an elderly person living with them or living independently nearby. "Either the elderly person comes to the agency for help or adult children ask for services related to a condition or problem of an elderly family member," explains Mr. Bernstein.

He says the elderly may have a medical problem or be dealing with "old unresolved family difficulties which have been accelerated by the fact that the person has aged." Family therapy often focuses on "how the adult child can deal supportively with the problem of the aging parent."

One-third of the family agency's caseload concerns problems of the elderly which are generally treated by a staff of six clinical social workers in JCSA's Services to the Aged unit. Other agency social workers and psychologists also carry cases involving the aged.



Although JCSA's experience has decidedly been otherwise, Mr. Bernstein says: "Some agencies are simply not interested in serving the aged, because they think that the elderly can't be helped."

Copies of the interim research paper on psychotherapeutic treatment of the elderly may be obtained from Martin Roth, Jewish Counseling and Service Agency of Metropolitan New Jersey, 161 Millburn Ave., Millburn, N.J. 07041.

ABA Pubs Help Lawyers To Aid the Elderly

Two publications, prepared by the Commission on Legal Problems of the Elderly of the American Bar Association (ABA), an interdisciplinary body concerned with legal problems faced by older persons, have been released.

Legal Services for the Elderly: Where the Nation Stands is designed to assist interested groups, especially bar associations, to establish or improve programs to meet the legal needs of the elderly. It describes the types of legal problems frequently encountered by the elderly, the responses of the Federal government and the organized private bar, and the role of private attorneys. The appendices are valuable references for information on legal problems of the elderly and include a list of State bar committees, private bar projects, and continuing legal education projects.

The second document, *Model Recommendations: Intermediate Sanctions for Enforcement of Quality of Care in Nursing Homes*, is designed to serve as a guide for States attempting to establish or improve nursing home regulatory systems.

Both publications are available free from the Commission on Legal Problems of the Elderly, American Bar Association, 1800 M St., N.W., Washington, D.C. 20036.

Benjamin Rose Institute Study on Family Care Of the Elderly

The Benjamin Rose Institute has released findings from its recent survey of 614 families who were living with and caring for a disabled older relative. The major purpose of the survey, funded by the Administration on Aging, was to discover what kinds of stressful effects family members experienced as a result of caring for an impaired aged relative and how extensive these stress effects are. Virtually all of the elderly cared for by their families required assistance with personal care activities, such as bathing, dressing, and grooming, and half were incontinent. Slightly more than half also had multiple symptoms of mental impairment such as forgetfulness, confusion, and poor judgment. Despite their severe physical and mental impairments, these elders had been receiving care from family members for an average of 6 years. Furthermore, the family unit was able to maintain itself successfully.

Keeping the elder relative at home, however, resulted in considerable demands on the time and energy of generally one family member — the "primary caregiver." These caregivers, who were the spouse or the adult child of the elder, estimated that they spent an average of 3 hours each day helping with personal care needs. The caregivers reported that the most difficult tasks involved lifting or moving the elder, while the task they found most upsetting was assisting the elder with toileting.

However, the findings showed that although all caregivers experienced some strain, only one out of five was severely affected. The most commonly reported stressful effect was that the caregivers' personal time was restricted because large amounts of time had to be devoted to the impaired elder's care. This complaint was particularly common among aged wives who were caring for their elderly and disabled husbands.

The caregivers who had the greatest difficulties were those who were caring for mentally impaired relatives who behaved in ways that disrupted the household. Certain types of families also appeared to find living with and caring for an older relative more problematic. These were typically three-generation households in which the primary caregiver had to meet the impaired elder's needs as well as those of her husband and children. Moreover, when the primary caregiver was a daughter-in-law rather than a daughter, the caregiver situation proved to be especially stressful.

Blood Transfusions Found To Be Effective In Treatment of Strokes

According to a University of Michigan Hospital study, increasing the heart's output, such as with a simple blood transfusion, relieves paralysis due to stroke, particularly in cases of cerebral vasospasm. This is a common form of stroke in which severe blood vessel constriction reduces or shuts off blood flow to the brain.

"Increasing general circulation promises to be a significant addition to treatment in the initial stages of stroke," said neurosurgeon Ted S. Keller, M.D. "By raising cardiac output in the laboratory, we successfully increased circulation to blood-starved areas of the brain. Applying these principles in stroke patients resulted in alleviation of paralysis in some cases, often within a few minutes, without endangering healthy brain tissue.

"Our laboratory study — along with actual clinical experience — shows this treatment to be safe, effective and relatively simple, since the heart automatically increases its output when blood or blood products are added to the body."

Julian T. Hoff, M.D., head of the U-M neurosurgery section, said Dr. Keller's findings increase understanding of the physiology of stroke, and suggest ways of improving treatment. "This new knowledge can immediately be put to use because it involves common methods of treatment safely used for a number of years in other conditions."

Aware that increasing blood volume by raising cardiac output and administering blood products has been a standard treatment for shock, Dr. Keller said that he and other U-M doctors speculated that increased blood flow also might alleviate paralysis due to stroke. This theory was corroborated by clinical observations at the U-M Hospitals. Following transfusions of blood products, or following elevation of blood pressure with drugs, a few patients in the initial stages of a stroke regained some movement with little or no treatment.

"Our clinical success has been the greatest in patients suffering stroke from cerebral vasospasm," Dr. Keller said. "But our experience in treatment of the more common form of stroke in patients with cerebral arteriosclerosis is increasing."

"We believe that the inciting factor for stroke in many patients at high risk with conditions such as arteriosclerosis and high blood pressure is a decrease in blood volume due to dehydration since at least half of the blood is water.

"We have seen many patients come to the hospital who have displayed dehydration at the onset of the stroke and alleviation of the dehydration has rapidly reversed the stroke," Dr. Keller said.

He emphasized that surgery on stroke patients should be performed to remove a blockage as a preventive measure against future strokes only after the patient has been stabilized by appropriate medical treatment.

Doctors have traditionally feared above-normal circulation in stroke patients because such patients usually suffer hypertension, Dr. Keller noted. Raising circulation "must be delicately controlled to avoid overtaxing blood vessels or the heart," he explained.

"While close monitoring of the heart is necessary," Dr. Keller said, "our study confirms others that show undamaged portions of the brain to be unaffected by increases in cardiac output. It appears that the healthy brain is self-regulated and maintains a constant blood flow regardless of the rest of the body's rate of activity."

Blood pressure in damaged brain tissue may remain constant while flow may vary, as in other parts of the body, because blood vessels are elastic and dilate to accommodate increased volume and flow.

By increasing blood flow and cardiac output, and by administering drugs to regulate vessel elasticity and lower blood pressure, Michigan doctors hope to develop a more effective stroke treatment.

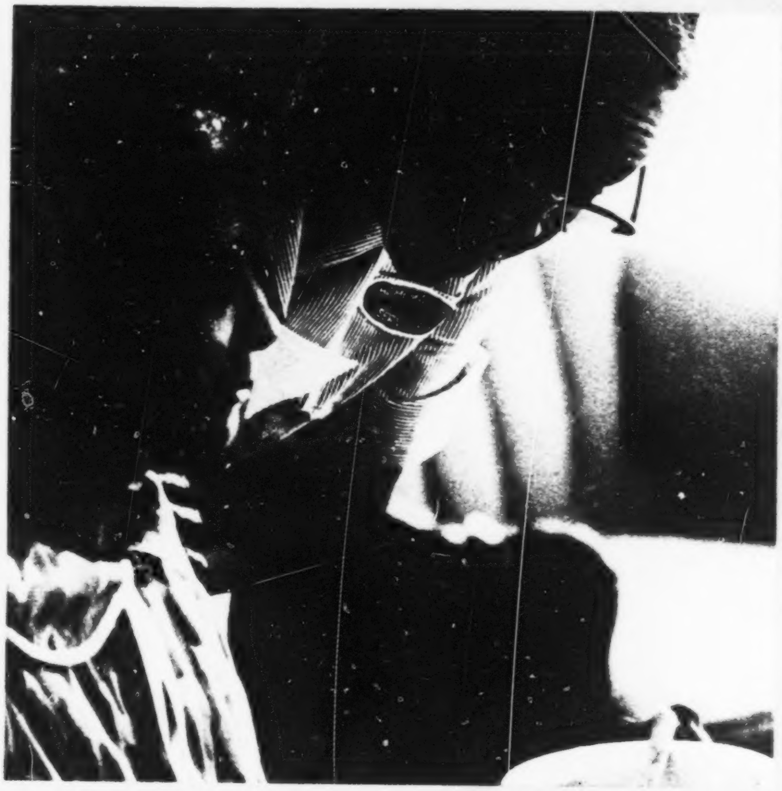
"Others have attempted to show that the use of certain drugs in stroke patients is valuable therapy because they make the blood more slippery and flow more readily to damaged brain tissue," Dr. Keller said. "We believe that the drugs are effective because they increase cardiac output and not because they make blood less viscous.

"Our next step," he continued, "is to examine our theories in an extensive clinical study to measure changes in blood flow and cardiac output directly on stroke patients and, hopefully, improve treatment further.

"We also want to run additional laboratory studies to determine more clearly the relationship between cardiac output and blood flow to the brain. We believe that cardiac output plays a larger role in reviving human brain tissue than is generally believed. Also, we don't fully understand why damaged areas of the brain give up self-regulation. Our aim, though, is to demonstrate that these natural responses of the body can be used for improving treatment."

Dr. Keller, who recently completed five years of neurosurgery training at the U-M, won the National Resident Award at the annual meeting of the Congress of Neurological Surgeons in Los Angeles for his findings on increasing the heart's output in treatment of stroke. He plans to join the faculty of the University of Colorado School of Medicine.

A report of Dr. Keller's laboratory research is scheduled for publication in a forthcoming edition of Clinical Neurosurgery, an annual collection of scientific papers published by the Congress of Neurological Surgeons.



More Older Workers Want Part-Time Work After Retirement

Four out of 10 workers 55 and older say they would prefer to continue working part-time after retirement, according to a recent study published by the National Council on the Aging (NCOA).

The study is based on a special analysis of data from NCOA's 1981 survey, *Aging in the Eighties: America in Transition*, conducted by Louis Harris and Associates. More than 3,400 persons 18 and older were interviewed, including 1,800 age 65 and over.

The NCOA study, *Part-Time Employment After Retirement*, by Drs. Harold Sheppard and Richard Mantovani, says that nearly 20 percent of all older employed men and women work part-time, compared to only 10 percent of workers 20-54 years old. "Economic necessity is a primary reason that older workers show a preference to continue working on a part-time basis after they leave their jobs," notes Dr. Sheppard, but he says psychological factors are also involved.

Older blacks, Hispanics and unmarried women, who typically have low-paying jobs and low pension coverage, opt to continue working in above average proportions, the study indicates.

While the majority of 55-plus workers surveyed who planned to continue working after retirement said they would prefer part-time employment in the same types of jobs they held, the authors questioned whether the kinds of jobs they performed would be available when they retired.

"Training and retraining of older workers — before they actually retire is more urgently needed in the eighties than in previous decades if the need and desire for employment in 'retirement years' is to be met," says Dr. Sheppard.

The NCOA study was supported by a grant from The Travelers Insurance Companies. Travelers has established several alternative work options for its retirees — a job bank, temporary employment program, permanent part-time work, and job sharing.

Part-Time Employment After Retirement may be purchased for $3.50 from the Publications Department, National Council on the Aging, 600 Maryland Ave., S.W., Washington, D.C. 20024. The NCOA also publishes a quarterly journal, *Aging and Work*, that addresses issues affecting older workers and their employees.

Publications

***Health Care Expenditures for the Elderly: How Much Protection Does Medicare Provide?* Senate Special Committee on Aging, G-233, Dirksen Senate Office Bldg., Washington, D.C. 20510. 1982. 8 pp. Available free.**

In anticipation of continuing debate on proposals to constrain the rapid growth in expenditures for the Medicare program, this information paper from the Senate Special Committee on Aging presents an analysis of current Medicare coverage and the costs of health care borne directly by the elderly. While noting that spending for Medicare has grown from $3.2 billion in 1967 to a projected $49.8 billion in 1982, the paper stresses that "proposals for reducing expenditures must be evaluated in light of their impact on the program's beneficiaries."

The paper examines the adequacy of Medicare's coverage "in light of expenditures by the elderly for services not covered by Medicare and the performance of other sources of payments (supplemental insurance and Medicaid) in meeting the shortfall between Medicare and total health expenditures."

Tables in the paper show that Medicare's share of total personal health care expenditures for the elderly rose from 35.3 percent in 1970 to 45 percent in 1980. The paper notes, however, that despite Medicare's increased share of the costs, the elderly person's per capita responsibility for his or her total health care bill grew from $503 in 1970 to $1,436 in 1980 — 19.1 percent of the average income of the elderly ($7,512) for that year. "Health care costs as a percentage of the elderly person's income," the paper points out, "are approaching the same share of income that health care costs consumed in 1965, prior to Medicare (20.4 percent)." The paper adds, however, that "evaluating Medicare's performance on the basis of its share of total health expenditures is somewhat misleading, since personal health care expenditures include nursing home costs . . . and other services which Medicare was never intended to cover."

Among other interesting facts found in the publication: Private insurance pays only a small portion of the elderly's total health expenditures (6.6 percent); and Blue Cross/Blue Shield Medicare supplemental insurance plans (held by over one-half of persons over 65 with any form of supplemental coverage) experienced rate increases of 24 to 37 percent in 1982, largely due to benefit increases and higher Medicare copayments.

In a concluding section, the report maintains that the tension between the two objectives of restraining Medicare expenditures and protecting the elderly from the increasing burden of health costs "may only be resolved through consideration of a wide range of alternatives for reform of the existing health care system."

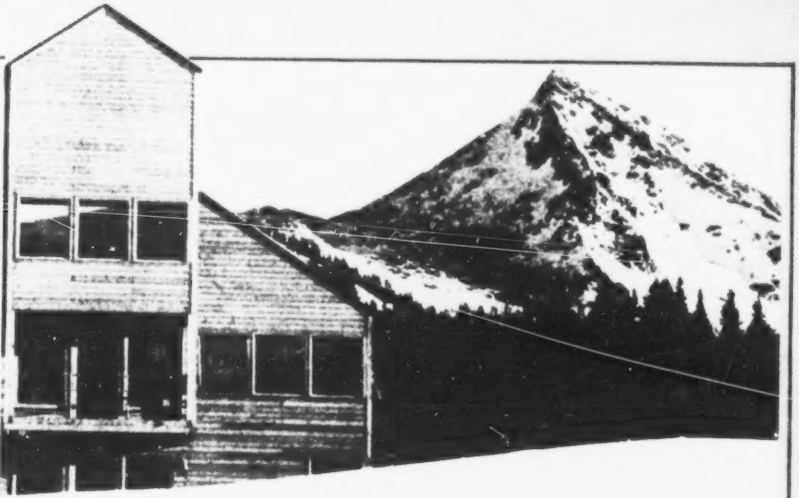
***The Three In One House: A Guide To Organizing and Operating a House for Three Older Persons.* Edited by Lorraine Hanaway. Home Care Research Inc., 30 East Patrick St., Frederick, Md. 21701. 46 pp. Appendices. Bibliography. 1981. $9.00.**

The Three In One House, based on Home Care Research Inc.'s experience in establishing small group homes, is a valuable guide to those individuals and agencies interested in setting up shared living arrangements for older persons. The greatest strength of this concise booklet is its practical how-to approach. It covers how to set up a small group home and includes sections on philosophy and goals, organization, policy, providing services, finances, initial steps, daily operation, record keeping, safety measures, special concerns and problems, and includes in the appendices copies of the forms and agreements being used.

The Three In One House is of interest also to those who are concerned with the issues of long term care and alternatives to institutionalization. Home Care Research started two separate homes in 1978 to demonstrate its philosophy that a greater choice of lifestyle is possible for the frail elderly. Residents lived together as families, maintained some of their independence, remained part of the community and retained their individual dignity. Home Care Research provided managerial staff and contracted with a licensed home health agency for housekeeping, meal and home health services, transportation, nursing, physical and speech therapy.

The Three In One House is available from Home Care Research Inc. at the rate of $9.00 for a single copy and $300 for 100 copies.

Carol Dingledein



***Retirement Edens Outside the Sunbelt.* By Peter A. Dickinson. E. P. Dutton, New York, N.Y. 1981. 294 pp. Bibliography and Index. Softback. $9.25.**

In writing this book, which is subtitled a "Complete Guide to the Best Places for Retirees in 26 States," Peter Dickinson says he traveled thousands of miles and "explored hundreds of Retirement Edens to suit every personal need and practical want."

To select the Edens he describes, Mr. Dickinson says he solicited and evaluated nominations from retirement specialists, directors of State units on aging and leading gerontologists; interviewed retirees who had recently moved to the towns he investigated; and relied on his own firsthand impressions.

He also used six yardsticks to rate his "garden spots" — favorable climate, affordable housing, moderate cost of living, reasonable costs for hospital and medical care, ample opportunities for recreation and culture, and availability of services for seniors.

The author organizes the best towns and areas for retirement first by region (New England, Mid-Atlantic, Midwest, etc.), with some general comments on charm, topography and taxation, and then by State, with further elaboration on living costs, health care, social services, housing, and culture. Finally, under each State, the reader will find detailed descriptions of a number of towns which are rated as adequate, good, or excellent for retirement.

New England, for example, is described as "a nice place to come home to . . . a land of heritage, Colonial charm, Currier and Ives scenes, and Christmas card settings. Even towns with grimy business districts," Mr. Dickinson a curately observes, "boast tidy residential areas with neat green shuttered houses and gleaming white steepled churches." But after evoking images of "the flaming fall foliage in Vermont, breakers pounding the rocky Maine coast, and green village commons in New Hampshire," Mr. Dickinson warns retirees "to bring money" because "charm costs, and taxes soar to pay the price."

Massachusetts is praised for being a leader in health care, culture, innovation in housing and services for seniors, but its income and property tax systems also receive careful scrutiny from the author. Twelve towns and areas in the Bay State are described in detail — Amherst, Great Barrington, Williamstown, Stockbridge, Southbridge, Sturbridge, the Cape Cod area, Martha's Vineyard, Holyoke, Weymouth, Arlington, and Nantucket.

Tables and charts help retirees to evaluate each State on the basis of its tax load for various income brackets, hospital costs and medical coverage, population growth, and climate.

Mr. Dickinson is enthusiastic about the challenges and opportunities that a change in locale can bring. "Your horizons are limited only by your vision," he tells retirees. "A move gets you out of a rut . . . Think about it: if you move to a place because you like it and it likes you, you should find more people of similar backgrounds and interests . . . Most of us didn't choose our present location. We moved here because of a job; if the job goes or gets stale, why stay?"

***Good Eating: An Older Consumer's Guide To A Healthful Diet On A Low Budget.* By S. J. Goodman. Consumer Affairs Division, Blue Cross and Blue Shield Associations, 1700 Pennsylvania Ave., N.W., Washington, D.C. 20006. 1981. 49 pp. Soft cover. $1.00.**

"Most people exercise less as they get older but seldom are appropriate changes made in diet to compensate for this," notes the forward to this nutrition guide and recipe book for older consumers. Published by Blue Cross and Blue Shield, the booklet was written by S. Jane Goodman, a nutritionist and biochemist, who has been working in recent years on integrating nutrition information and diet therapy into community programs for the elderly.

In addition to 50 recipes for easy-to-prepare meals, kitchen-tested by the author, the book includes sections on the nutritional needs of older persons, basic food groups, economy shopping, exercise, and diet suggestions for elderly people with special problems. The recipe section also contains instructions for preparing and cooking vegetables and menu suggestions for balanced meals.

***Model Adult Protective Services Law.* Nassau Division, National Association of Social Workers, Hempstead, N.Y. 1982. 10 pp.**

Having developed model regulatory standards for adult homes in 1978, the Ad Hoc Committee on Adult Homes in the Nassau County, N.Y. chapter of NASW turned its attention to neglect and exploitation of adults living outside of group homes. The result was the preparation of a model protective services law designed to protect vulnerable adults from maltreatment and neglect, failure to receive adequate food, shelter and clothing, and deprivation of entitlements due to their own incapacities or the action or inaction of others.

In an introduction to the model law, the Ad Hoc Committee says that notable among these adults in jeopardy are the "deinstitutionalized, those who in effect have been abandoned by the institution which formerly cared for them." Many others are in need of protection, the Committee notes, due to advanced age and enfeeblement.

Among the model statute's provisions are ones that would provide for:

- an adult protective services unit in every local department of social services.
- a state central registry capable of receiving reports at any time of the day or night.
- mandatory reporting of adults in jeopardy by specified professionals.
- authority of a social service agency to intervene immediately to provide food, heat, and/or supervision to an endangered adult without his or her consent prior to seeking a provisional protective order from a court.
- assignment of counsel to represent the endangered adult in a court hearing.

The introduction to the statute stresses that the majority of endangered adults are not recognized as in need of protection. "Little has been done to develop the public awareness, the procedures, or systematic linkages necessary to lead to their identification."

Single copies of the model statute may be obtained free from: Marian Goldstein, Chairperson of the Ad Hoc Committee on Adult Homes, Jewish Institute for Geriatric Care, 271-11 76th Ave., New Hyde Park, N.Y. 11042. Telephone: (212) 343-2100.

***International Survey of Periodicals in Gerontology.* The International Federation on Aging, 1909 K St., N.W., Washington, D.C. 20049. 1982. 92 pp. Index. $10.00. Soft cover.**

This survey, which updates one published by the International Federation on Aging in 1978, lists all publications throughout the world that are either entirely devoted to the subject of gerontology or regularly carry articles of interest in the field of aging. The publications, arranged in alphabetical order by country, are coded to indicate the primary audience — the aged themselves, social service providers, health care professionals, or researchers focusing on the bio-medical aspects of aging.

***Health Groups In Washington: A Directory.* National Health Council, 70 West 40th St., New York, N.Y. 10018. 1982. 49 pp. $4.00.**

This 7th edition of the directory lists 249 national health organizations which are either headquartered in Washington, D.C. or have an office or representative in the Washington Metropolitan Area. Each entry gives the name, address and phone of the organization and the name of the chief executive and/or Washington representative. Printed in a 4 x 9 inch pocket-size format, the directory includes an extensive subject index.

***An International Perspective on the Status of Older Women.* By Sheila M. Peace. International Federation on Aging, 1909 K Street, N.W., Washington, D.C. 20049. 1981. 91 pp. $5.00. Soft cover.**

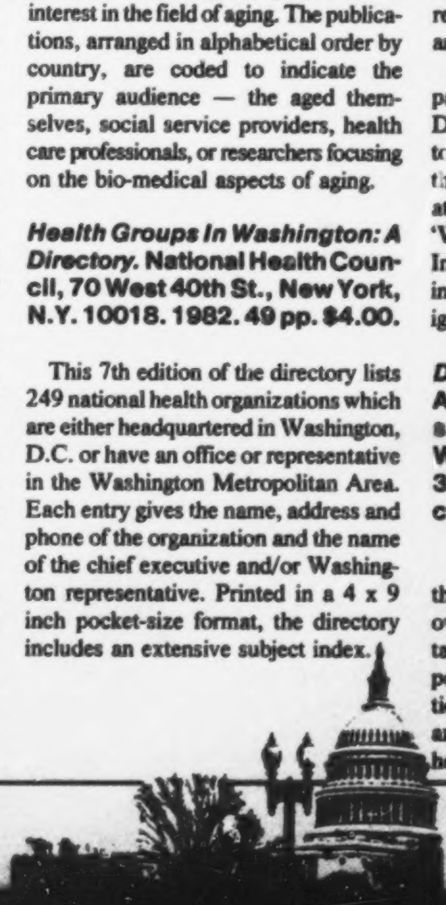
This monograph presents a demographic and sociological profile of older women around the world and explores the roles they play, their family life, the images others have of them, and their health and income status.

The study pulls together a wide range of international sources of data on older women, including information provided by members of the International Federation on Aging (IFA) on the position of older women in their societies. Extensive references and supporting tables are presented in the report's seven chapters which cover such topics as education, living arrangements, employment, family-related roles, health and mental health, and income, pensions, and social security.

Originally prepared as a background paper for the U.N.'s conference on the Decade for Women by British gerontologist Dr. Sheila Peace, the IFA notes that the monograph was written "in an attempt to redress the balance of the 'World Plan of Action,' adopted at the International Women's Year Conference in Mexico City in 1975, which largely ignored older women."

***Data Track 9: Older Americans.* American Council of Life Insurance, 1850 K St., N.W., Washington, D.C. 20006. 1982. 32 pp. Soft cover. Single copies free.**

Data Tract 9 reviews the changes in the American population 65 and older over the past two decades. Statistical tables showing trends in the older population's growth, mortality, educational attainment, residence, living arrangements, labor force participation, health, and income are presented. The



pamphlet includes statistics on leading causes of death among older persons, the over-85 age group, the growth of minority older people, the aged living in poverty, and on nursing home residents.

***Supervision in Home Care: Manual for Supervisors.* National Homecaring Council, 67 Irving Place, New York, N.Y. 10003. 1982. 251 pp. $20.00. Soft cover. Index and Bibliographies.**

***A Better Answer: Supervision in Home Care - A Training Guide for Instructors.* National Homecaring Council, 67 Irving Place, New York, N.Y. 10003. 1982. 177 pp. Large loose-leaf notebook. $35.00.**

Developed by the National Homecaring Council under a 3-year $285,000 grant from AoA's Title IV-A National Continuing Education Program, these companion manuals are intended to meet a pressing need in the home care field — adequate training for supervisors of home care services. According to the Council, while there are training opportunities for homecare professionals, aides and volunteers, few materials or programs are available to train their supervisors who are responsible for coordinating a range of in-home services. Under the rubric of home care, the Council includes nursing, counseling and therapeutic services, and homemaker/home health aid as well as chore services, home delivered meals, telephone reassurance, and friendly visiting.

Section I of the new manual for supervisors provides an overview of the development of home care services in the U.S. and reviews Federal legislation affecting the financing of home health care. This section also discusses the chief components of home care services; the special skills required in supervising services provided in the home; and major client populations, including abused children, chronically impaired young people, teenage mothers and their infants, the developmentally disabled, the mentally ill, and elderly people with chronic illnesses and disabilities.

Section II deals with the knowledge, skills and attitudes needed for effective supervision in any setting and describes the unique characteristics of home care. Among the topics covered are setting agency objectives; hierarchies within organizations; the functions of supervision (controlling, planning, directing, organizing, and staffing); communication and leadership skills; and avoiding burnout in direct service workers.

Section III analyzes the tasks of supervision in case management from intake, assessment and case planning to termination of clients and case recording. Other subjects include recruitment of workers, staffing, disciplinary action, interagency coordination and community relations. At the end of the manual is a section containing about 20 sample forms for use by home care agencies, including intake, family history, health information and service application forms for clients and job descriptions for home care workers.

A Better Answer: Supervision in Home Care - A Training Guide for Instructors is the companion piece to the basic manual for supervisors and parallels its content. A large, loose-leaf notebook, the 177-page guide for trainers of home care supervisors elaborates on the key points made in the basic manual and provides suggestions for presenting issues during training sessions. Questions, case examples, exercises and handouts are interspersed throughout the guide.

According to the National Homecaring Council, the material and approach in these two publications were "drawn from the experience of practitioners in the home care field (primarily nurses and social workers) . . . and from the wealth of material on management developed by business and industry and readily applicable to supervision in home care."

The Truth About Cataracts

In the January-February issue of Aging we stated that the "Truth About Cataracts" could be ordered from the publisher.

The book can now be ordered directly from the author Dr. Arthur Fleming, 2020 Ardmore Blvd., Pittsburgh, Pa. 15221. Telephone: (412) 271-2400.

Course & Conference Calendar

Jan. 10-14. *Winter/Spring Institute on Aging: Unusual Clients, The Service Provider's Challenge.* Eleanor Adams, Center for Studies in Aging, P.O. Box 13438, NT Station, Denton, TX. 76203. (817) 565-3449 or 565-2765.

Jan. 10-14 and May 16-20. *The Center for Studies in Aging Winter/Spring Institute on Aging. Unvsual Clients: The Service Provider's Challenge.* Eleanor Adams, Academic Program Coordinator, Center for Studies in Aging, P.O. Box 13438, NT Station, Denton, TX. 76203. (817) 565-3449 or 565-2765.

Jan. 11. *Mental Health and Aging: The Team Approach*, Dr. Jim Kelly, California State University, Department of Social Work, Long Beach, CA. 90840. (213) 498-5794.

Jan. 12. *Mental Health and Aging: The Team Approach*, Dr. Anita Harbert, California State University, School of Social Work, San Diego, CA. 92182. (714) 265-6310.

Jan. 13. *Mental Health and Aging: The Team Approach*, Sue Reid, Honolulu Area Agency on Aging, Honolulu, HI. 96813. (808) 523-4361.

Feb. 20-22. *The Tenth National Institute on Minority Aging: Surviving Today's Economy - Resources, Strategies, and Techniques.* In Los Angeles. Shirley A. Lockery, Ph.D., Associate Director, Planning & Operations, University Center on Aging, San Diego State University, San Diego, CA. 92182. (714) 265-4169; or Josephine E. Yelder, D.S.W., Social Science Division, Pepperdine University, 24255 Pacific Coast Highway, Malibu, CA. 90265. (212) 747-9611.

Mar. 12-16. *The National Council on Aging's 33rd Annual Conference: Exploring Elements of a Caring Society.* At Westin Hotel, Renaissance Center, Detroit, MI. Nancy Peavy or Ruth Blank, NCOA, 600 Maryland Ave., S.W., Washington, D.C. 20024. (202) 479-1200.

Apr. 26-29. *Mid-America Congress on Aging 10th Annual Conference: Convergency in Aging: Bridging the Aging Aging Networks.* At the Sheraton-Royal Hotel, Kansas City, MO. Marcia Neu, Administrator, Mid-America Congress on Aging, 701 N. 7th St., Room 510, Kansas City, KN. 66101. (913) 371-2000, Ext. 428.

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Information for Conference Calendar and course Calendar should be submitted at least 12 weeks prior to the issue month in which they are to appear.

All material should be sent to Editor, AGING Magazine, Administration on Aging, Room 4639, 330 Independence Avenue, S.W., Washington, D.C. 20201.

Information

Information about articles appearing in or submitted to AGING Magazine may be obtained by writing the Editor at the above address or by calling (202) 245-1826

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